

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
*****	FI INPATIENT SNF CLAIM RECORD	REC	VAR			FISCAL INTERMEDIARY INPATIENT/SNF CLAIM RECORD FOR VERSION I OF THE NCH. STANDARD ALIAS: FI_IP_SNF_CLM_REC SYSTEM ALIAS: UTLIPSNI
*****	FI INPATIENT SNF CLAIM FIXED GROUP	GROUP	805	1	805	FIXED PORTION OF THE FISCAL INTERMEDIARY INPATIENT/SN CLAIM RECORD FOR VERSION I OF THE NCH NEARLINE FILE. STANDARD ALIAS: FI_IP_SNF_CLM_FIX_GRP
*****	CLAIM RECORD IDENTIFICATION GROUP	GROUP	8	1	8	EFFECTIVE WITH VERSION 'I' THE RECORD LENGTH, VERSION CODE, RECORD IDENTIFICATION, CODE AND NCH DERIVED CLAIM TYPE CODE WERE MOVED TO THIS GROUP FOR INTERNAL NCH PROCESSING. STANDARD ALIAS: CLM_REC_IDENT_GRP
1.	RECORD LENGTH COUNT	PACK	3	1	3	EFFECTIVE WITH VERSION H, THE COUNT (IN BYTES) OF THE LENGTH OF THE CLAIM RECORD. NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991). 5 DIGITS SIGNED DB2 ALIAS: REC_LNGTH_CNT SAS ALIAS: REC_LEN STANDARD ALIAS: REC_LNGTH_CNT SOURCE: NCH
2.	NCH NEAR-LINE RECORD	CHAR	1	4	4	THE CODE INDICATING THE RECORD VERSION OF THE NEARLIN

VERSION CODE

WHERE THE INSTITUTIONAL, CARRIER OR DMERC CLAIMS DATA
STORED.

DB2 ALIAS: NCH_REC_VRSN_CD

SAS ALIAS: REC_LVL

STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD

TITLE ALIAS: NCH_VERSION

CODES:

A = RECORD FORMAT AS OF JANUARY 1991

B = RECORD FORMAT AS OF APRIL 1991

C = RECORD FORMAT AS OF MAY 1991

D = RECORD FORMAT AS OF JANUARY 1992

E = RECORD FORMAT AS OF MARCH 1992

F = RECORD FORMAT AS OF MAY 1992

G = RECORD FORMAT AS OF OCTOBER 1993

H = RECORD FORMAT AS OF SEPTEMBER 1998

I = RECORD FORMAT AS OF JULY 2000

COMMENT:

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			BEG	END	
					PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_NEAR_LINE_REC_VRSN_CD.
					SOURCE: NCH
3. NCH NEAR LINE RECORD IDENTIFICATION CODE	CHAR	1	5	5	A CODE DEFINING THE TYPE OF CLAIM RECORD BEING PROCES COMMON ALIAS: RIC DB2 ALIAS: NEAR_LINE_RIC_CD SAS ALIAS: RIC_CD STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD TITLE ALIAS: RIC CODES: REFER TO: NCH_NEAR_LINE_RIC_TB IN THE CODES APPENDIX COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:
RIC_CD.

SOURCE:
NCH

Field Number	Field Name	Type	Length	Start Pos	End Pos	Description
4.	NCH MQA RIC CODE	CHAR	1	6	6	EFFECTIVE WITH VERSION H, THE CODE USED (FOR INTERNAL EDITING PURPOSES) TO IDENTIFY THE RECORD BEING PROCESSED THROUGH HCFA'S CWFMQA SYSTEM.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97
FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED
TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.

DB2 ALIAS: NCH_MQA_RIC_CD
SAS ALIAS: MQA_RIC
STANDARD ALIAS: NCH_MQA_RIC_CD
TITLE ALIAS: MQA_RIC

CODES:
1 = INPATIENT
2 = SNF
3 = HOSPICE
4 = OUTPATIENT
5 = HOME HEALTH AGENCY
6 = PHYSICIAN/SUPPLIER
7 = DURABLE MEDICAL EQUIPMENT

SOURCE:
NCH QA PROCESS

Field Number	Field Name	Type	Length	Start Pos	End Pos	Description
5.	NCH CLAIM TYPE CODE	CHAR	2	7	8	THE CODE USED TO IDENTIFY THE TYPE OF CLAIM RECORD BE PROCESSED IN NCH.

NOTE1: DURING THE VERSION H CONVERSION THIS FIELD WAS
POPULATED WITH DATA THROUGH- OUT HISTORY (BAC
SERVICE YEAR 1991).

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			BEG	END	
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NOTE2: DURING THE VERSION I CONVERSION THIS FIELD WAS

EXPANDED TO INCLUDE INPATIENT 'FULL' ENCOUNTER CLAIMS (FOR SERVICE DATES AFTER 6/30/97).
PLACEHOLDERS FOR PHYSICIAN AND OUTPATIENT ENC (AVAILABLE IN NMUD) HAVE ALSO BEEN ADDED.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPE
TITLE ALIAS: CLAIM_TYPE

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
NCH_CLM_NEAR_LINE_RIC_CD
NCH_PMT_EDIT_RIC_CD
NCH_CLM_TRANS_CD
NCH_PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(PRE-HDC PROCESSING -- AVAILABLE IN NCH)
CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(HDC PROCESSING -- AVAILABLE IN NMUD)
FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC PROCESSING -- AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

NOTE: FROM 7/1/97 TO THE START OF HDC PROCESSING(?),
ABBREVIATED INPATIENT ENCOUNTER CLAIMS ARE NOT
AVAILABLE IN NCH OR NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(AVAILABLE IN NMUD)
CARR_NUM

CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(AVAILABLE IN NMUD)

FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM: (AVAILABLE IN NMUD)

FI_NUM

CLM_FAC_TYPE_CD

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			BEG	END	
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					CLM_SRVC_CLSFCTN_TYPE_CD
					CLM_FREQ_CD

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V', 'W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)

1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
CLSFCN_TYPE_CD = '2', '3' OR '4' &
CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
					2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
					3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
					SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_MCO_PD_SW = '1'
					2. CLM_RLT_COND_CD = '04'
					3. MCO_CNTRCT_NUM
					MCO_OPTN_CD = 'C'
					CLM FROM DT & CLM THRU DT ARE WITHIN THE

MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:

1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O NON-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD NOT ON DMEPOS TABLE

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD ON DMEPOS TABLE (NOTE: IF ONE OR
MORE LINE ITEM(S) MATCH THE HCPCS ON THE
DMEPOS TABLE).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
CONDITIONS ARE MET:

1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M NON-DMEPOS DMERC
CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD NOT ON DMEPOS TABLE

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD ON DMEPOS TABLE (NOTE: IF ONE OR MORE LINE ITEM(S) MATCH THE HCPCS ON THE DMEPOS TABLE). CODES: REFER TO: NCH_CLM_TYPE_TB IN THE CODES APPENDIX SOURCE: NCH
**** FISCAL INTERMEDIARY CLAIM LINK GROUP	GROUP	125	9	133	EFFECTIVE WITH VERSION 'I', THIS GROUP CONTAINS THOSE FIELDS NECESSARY TO KEEP RECORDS/ SEGMENTS TOGETHER (A CLAIM MAY HAVE UP TO 10 RECORDS/ SEGMENTS DUE TO THE INCREASE IN NUMBER OF REVENUE CENTER TRAILERS (UP TO 450). IT IS ALSO USED TO HOUSE FIELDS NECESSARY FOR SORTING AND FINAL ACTION PROCESSING. STANDARD ALIAS: FI_CLM_LINK_GRP
**** CLAIM LOCATOR NUMBER GROUP	GROUP	11	9	19	THIS NUMBER UNIQUELY IDENTIFIES THE BENEFICIARY IN THE NCH NEARLINE. COMMON ALIAS: HIC STANDARD ALIAS: CLM_LCTR_NUM_GRP TITLE ALIAS: HICAN
6. BENEFICIARY CLAIM ACCOUNT NUMBER	CHAR	9	9	17	THE NUMBER IDENTIFYING THE PRIMARY BENEFICIARY UNDER THE SSA OR RRB PROGRAMS SUBMITTED. COMMON ALIAS: CAN DA3 ALIAS: CLAIM_ACCOUNT_NUMBER DB2 ALIAS: BENE_CLM_ACNT_NUM SAS ALIAS: CAN STANDARD ALIAS: BENE_CLM_ACNT_NUM TITLE ALIAS: CAN

SOURCE:
SSA,RRB

LIMITATIONS:
RRB-ISSUED NUMBERS CONTAIN AN OVERPUNCH IN
THE FIRST POSITION THAT MAY APPEAR AS A PLUS
ZERO OR A-G. RRB-FORMATTED NUMBERS MAY
CAUSE MATCHING PROBLEMS ON NON-IBM MACHINES.

7. NCH CATEGORY EQUATABLE
BENEFICIARY IDENTIFICATION
CODE

CHAR

2

18

19

THE CODE CATEGORIZING GROUPS OF BICS
REPRESENTING SIMILAR RELATIONSHIPS BETWEEN
THE BENEFICIARY AND THE PRIMARY WAGE EARNER.

THE EQUATABLE BIC MODULE ELECTRONICALLY MATCHES
TWO RECORDS THAT CONTAIN DIFFERENT BICS WHERE
IT IS APPARENT THAT BOTH ARE RECORDS FOR THE
SAME BENEFICIARY. IT VALIDATES THE BIC AND

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			BEG	END	
					<p>RETURNS A BASE BIC UNDER WHICH TO HOUSE THE RECORD IN THE NATIONAL CLAIMS HISTORY (NCH) DATABASES. (ALL RECORDS FOR A BENEFICIARY ARE STORED UNDER A SINGLE BIC.)</p> <p>COMMON ALIAS: NCH_BASE_CATEGORY_BIC DB2 ALIAS: CTGRY_EQTBL_BIC SAS ALIAS: EQ_BIC STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD TITLE ALIAS: EQUATED_BIC</p> <p>CODES: REFER TO: CTGRY_EQTBL_BENE_IDENT_TB IN THE CODES APPENDIX</p> <p>COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: CTGRY_EQTBL_BENE_IDENT_CD.</p> <p>SOURCE: BIC EQUATE MODULE</p>

8. BENEFICIARY IDENTIFICATION CHAR 2 20 21 THE CODE IDENTIFYING THE TYPE OF RELATIONSHIP BETWEEN INDIVIDUAL AND A PRIMARY SOCIAL SECURITY ADMINISTRATI (SSA) BENEFICIARY OR A PRIMARY RAILROAD BOARD (RRB) BENEFICIARY.

COMMON ALIAS: BIC
 DA3 ALIAS: BENE_IDENT_CODE
 DB2 ALIAS: BENE_IDENT_CD
 SAS ALIAS: BIC
 STANDARD ALIAS: BENE_IDENT_CD
 TITLE ALIAS: BIC

EDIT-RULES:
 EDB REQUIRED FIELD

CODES:
 REFER TO: BENE_IDENT_TB
 IN THE CODES APPENDIX

SOURCE:
 SSA/RRB

9. NCH STATE SEGMENT CODE CHAR 1 22 22 THE CODE IDENTIFYING THE SEGMENT OF THE NCH NEARLINE CONTAINING THE BENEFICIARY'S RECORD FOR A SPECIFIC SE YEAR. EFFECTIVE 12/96, SEGMENTATION IS BY CLM_LCTR_N THEN FINAL ACTION SEQUENCE WITHIN RESIDENCE STATE. (TO 12/96, SEGMENTATION WAS BY RANGES OF COUNTY CODES THE RESIDENCE STATE.)

DB2 ALIAS: NCH_STATE_SGMT_CD
 SAS ALIAS: ST_SGMT
 STANDARD ALIAS: NCH_STATE_SGMT_CD
 TITLE ALIAS: NEAR_LINE_SEGMENT

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			BEG	END	
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CODES:
 REFER TO: NCH_STATE_SGMT_TB
 IN THE CODES APPENDIX

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:
BENE_STATE_SGMT_NEAR_LINE_CD.

SOURCE:
NCH

10. BENEFICIARY RESIDENCE SSA	CHAR	2	23	24	THE SSA STANDARD STATE CODE OF A BENEFICIARY'S RESIDE
STANDARD STATE CODE					

DA3 ALIAS: SSA_STANDARD_STATE_CODE
DB2 ALIAS: BENE_SSA_STATE_CD
SAS ALIAS: STATE_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

COMMENT:

1. USED IN CONJUNCTION WITH A COUNTY CODE, AS SELECTION CRITERIA FOR THE DETERMINATION OF PAYMENT RATES FOR HMO REIMBURSEMENT.
2. CONCERNING INDIVIDUALS DIRECTLY BILLABLE FOR PART B AND/OR PART A PREMIUMS, THIS ELEMENT IS USED TO DETERMINE IF THE BENEFICIARY WILL RECEIVE A BILL IN ENGLISH OR SPANISH.
3. ALSO USED FOR SPECIAL STUDIES.

SOURCE:
SSA/EDB

11. CLAIM FROM DATE	NUM	8	25	32	THE FIRST DAY ON THE BILLING STATEMENT COVERING SERVICES RENDERED TO THE BENE-FICIARY (A.K.A. 'STATEMENT COVERS FROM DATE').
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NOTE: FOR HOME HEALTH PPS CLAIMS, THE 'FROM' DATE AND THE 'THRU' DATE ON THE RAP (INITIAL CLAIM) MUST ALWAYS MATCH.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_FROM_DT
SAS ALIAS: FROM_DT
STANDARD ALIAS: CLM_FROM_DT
TITLE ALIAS: FROM_DATE

EDIT-RULES:
YYYYMMDD

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			BEG	END	
12. CLAIM THROUGH DATE	NUM	8	33	40	<p>SOURCE: CWF</p> <p>THE LAST DAY ON THE BILLING STATEMENT COVERING SERVICES RENDERED TO THE BENEFICIARY (A.K.A 'STATEMENT COVERS THRU DATE').</p> <p>NOTE: FOR HOME HEALTH PPS CLAIMS, THE 'FROM' DATE AND THE 'THRU' DATE ON THE RAP (INITIAL CLAIM) MUST ALWAYS MATCH.</p> <p>8 DIGITS UNSIGNED</p> <p>DB2 ALIAS: CLM_THRU_DT SAS ALIAS: THRU_DT STANDARD ALIAS: CLM_THRU_DT TITLE ALIAS: THRU_DATE</p> <p>EDIT-RULES: YYYYMMDD</p> <p>SOURCE: CWF</p>
13. NCH WEEKLY CLAIM PROCESSING DATE	NUM	8	41	48	<p>THE DATE THE WEEKLY NCH DATABASE LOAD PROCESS CYCLE BEGINS, DURING WHICH THE CLAIM RECORDS ARE LOADED INTO THE NEARLINE FILE. THIS DATE WILL ALWAYS BE A FRIDAY, ALTHOUGH THE CLAIMS WILL ACTUALLY BE APPENDED TO THE DATABASE SUBSEQUENT TO THE DATE.</p>

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_WKLY_PROC_DT
SAS ALIAS: WKLY_DT
STANDARD ALIAS: NCH_WKLY_PROC_DT
TITLE ALIAS: NCH_PROCESS_DT

EDIT-RULES:
YYYYMMDD

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
HCFA_CLM_PROC_DT.

SOURCE:
NCH

14. CWF CLAIM ACCRETION DATE NUM 8 49 56 THE DATE THE CLAIM RECORD IS ACCRETED (POSTED/
PROCESSED) TO THE BENEFICIARY MASTER RECORD
AT THE CWF HOST SITE AND AUTHORIZATION FOR
PAYMENT IS RETURNED TO THE FISCAL INTERME-
DIARY OR CARRIER.

8 DIGITS UNSIGNED

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					DB2 ALIAS: CWF_CLM_ACRTN_DT SAS ALIAS: ACRTN_DT STANDARD ALIAS: CWF_CLM_ACRTN_DT TITLE ALIAS: ACCRETION_DT
					EDIT-RULES: YYYYMMDD
					SOURCE: CWF
15. CWF CLAIM ACCRETION NUMBER	PACK	2	57	58	THE SEQUENCE NUMBER ASSIGNED TO THE CLAIM RECORD WHEN ACCRETED (POSTED/PROCESSED) TO THE BENEFICIARY MASTER RECORD AT THE CWF HOST

SITE ON A GIVEN DATE. THIS ELEMENT INDICATES THE POSITION OF THE CLAIM WITHIN THAT DAY'S PROCESSING AT THE CWF HOST. ** (EXCEPTION: IF THE CLAIM RECORD IS MISSING THE ACCRETION DATE HCFA'S CWFMQA SYSTEM PLACES A ZERO IN THE ACCRETION NUMBER.

3 DIGITS SIGNED

DB2 ALIAS: CWF_CLM_ACRTN_NUM
SAS ALIAS: ACRTN_NM
STANDARD ALIAS: CWF_CLM_ACRTN_NUM
TITLE ALIAS: ACCRETION_NUMBER

SOURCE:
CWF

16.	FI DOCUMENT CLAIM CONTROL NUMBER	CHAR	23	59	81	UNIQUE CONTROL NUMBER ASSIGNED BY AN INTERMEDIARY TO AN INSTITUTIONAL CLAIM.
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COMMON ALIAS: ICN
DB2 ALIAS: DOC_CLM_CNTL_NUM
SAS ALIAS: CLM_CNTL
STANDARD ALIAS: FI_DOC_CLM_CNTL_NUM
TITLE ALIAS: ICN

SOURCE:
CWF

17.	FI ORIGINAL CLAIM CONTROL NUMBER	CHAR	23	82	104	EFFECTIVE WITH VERSION G, THE ORIGINAL INTERMEDIARY CONTROL NUMBER (ICN) WHICH IS PRESENT ON ADJUSTMENT CLAIMS, REPRESENTING THE ICN OF THE ORIGINAL TRANSACTION NOW BEING ADJUSTED.
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COMMON ALIAS: ORIGINAL_ICN
DB2 ALIAS: ORIG_CLM_CNTL_NUM
SAS ALIAS: ORIGCNTL
STANDARD ALIAS: FI_ORIG_CLM_CNTL_NUM
TITLE ALIAS: ORIGINAL_ICN

SOURCE:

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POSITIONS

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					CWF
18. CLAIM QUERY CODE	CHAR	1	105	105	<p>CODE INDICATING THE TYPE OF CLAIM RECORD BEING PROCESSED WITH RESPECT TO PAYMENT (DEBIT/CREDIT INDICATOR; INTERIM/FINAL INDICATOR).</p> <p>DB2 ALIAS: CLM_QUERY_CD SAS ALIAS: QUERY_CD STANDARD ALIAS: CLM_QUERY_CD TITLE ALIAS: QUERY_CD</p> <p>CODES: 0 = CREDIT ADJUSTMENT 1 = INTERIM BILL 2 = HOME HEALTH AGENCY (HHA) BENEFITS EXHAUSTED (OBSOLETE 7/98) 3 = FINAL BILL 4 = DISCHARGE NOTICE (OBSOLETE 7/98) 5 = DEBIT ADJUSTMENT</p> <p>SOURCE: CWF</p>
19. PROVIDER NUMBER	CHAR	6	106	111	<p>THE IDENTIFICATION NUMBER OF THE INSTITUTIONAL PROVIDER CERTIFIED BY MEDICARE TO PROVIDE SERVICES TO THE BENEFICIARY.</p> <p>DB2 ALIAS: PRVDR_NUM SAS ALIAS: PROVIDER STANDARD ALIAS: PRVDR_NUM TITLE ALIAS: PROVIDER_NUMBER</p> <p>CODES: REFER TO: PRVDR_NUM_TB IN THE CODES APPENDIX</p> <p>SOURCE: OSCAR</p>
20. NCH DAILY PROCESS DATE	NUM	8	112	119	<p>EFFECTIVE WITH VERSION H, THE DATE THE CLAIM RECORD WAS PROCESSED BY HCFA'S CWFMA SYSTEM (USED FOR INTERNAL PURPOSES).</p>

EFFECTIVE WITH VERSION I, THIS DATE IS USED IN CONJUN
WITH THE NCH SEGMENT LINK NUMBER TO KEEP CLAIMS WITH
MULTIPLE RECORDS/ SEGMENTS TOGETHER.

NOTE1: WITH VERSION 'H' THIS FIELD WAS POP- ULATED W
DATA BEGINNING WITH NCH WEEKLY PROCESS DATE 1
UNDER VERSION 'I' CLAIMS PRIOR TO 10/3/97, TH
BLANK UNDER VERSION 'H', WERE POPULATED WITH .

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_DAILY_PROC_DT
SAS ALIAS: DAILY_DT

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			BEG	END	
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					STANDARD ALIAS: NCH_DAILY_PROC_DT TITLE ALIAS: DAILY_PROCESS_DT
					EDIT-RULES: YYYYMMDD
					SOURCE: NCH
21. NCH SEGMENT LINK NUMBER	PACK	5	120	124	EFFECTIVE WITH VERSION 'I', THE SYSTEM GEN- ERATED NUMBER USED IN CONJUNCTION WITH THE NCH DAILY PROCESS DATE TO KEEP RECORDS/SEGMENTS BELONGING TO A SPECIFIC CLAIM TOGETHER. THIS FIELD WAS ADDED TO ENSURE THAT RECORDS/ SEGMENTS THAT COME IN ON THE SAME BATCH WITH THE SAME IDENTIFYING INFORMATION IN THE LINK GROUP ARE NOT MIXED WITH EACH OTHER.
					NOTE: DURING THE VERSION I CONVERSION THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).
					9 DIGITS SIGNED
					DB2 ALIAS: NCH_SGMT_LINK_NUM

SAS ALIAS: LINK_NUM
STANDARD ALIAS: NCH_SGMT_LINK_NUM
TITLE ALIAS: LINK_NUM

SOURCE:
NCH

22. CLAIM TOTAL SEGMENT COUNT NUM 2 125 126 EFFECTIVE WITH VERSION I, THE COUNT USED
TO IDENTIFY THE TOTAL NUMBER OF SEGMENTS
ASSOCIATED WITH A GIVEN CLAIM. EACH CLAIM
COULD HAVE UP TO 10 SEGMENTS.

NOTE: DURING THE VERSION I CONVERSION, THIS
FIELD WAS POPULATED WITH DATA THROUGHOUT
HISTORY (BACK TO SERVICE YEAR 1991).
FOR INSTITUTIONAL CLAIMS, THE COUNT
FOR CLAIMS PRIOR TO 7/00 WILL BE 1 OR 2
(1 IF 45 OR LESS REVENUE CENTER LINES ON A
CLAIM AND 2 IF MORE THAN 45 REVENUE CENTER
LINES ON A CLAIM). FOR NONINSTITUTIONAL
CLAIMS, THE COUNT WILL ALWAYS BE 1.

2 DIGITS UNSIGNED

DB2 ALIAS: TOT_SGMT_CNT
SAS ALIAS: SGMT_CNT
STANDARD ALIAS: CLM_TOT_SGMT_CNT
TITLE ALIAS: SEGMENT_COUNT

SOURCE:
CWF

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
23. CLAIM SEGMENT NUMBER	NUM	2	127	128	EFFECTIVE WITH VERSION I, THE NUMBER USED TO IDENTIFY AN ACTUAL RECORD/SEGMENT (1 - 10) ASSOCIATED WITH A GIVEN CLAIM.
NOTE: DURING THE VERSION I CONVERSION THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).					

FOR INSTITUTIONAL CLAIMS PRIOR TO 7/00,
THIS NUMBER WILL BE EITHER 1 OR 2. FOR
NONINSTITUTIONAL CLAIMS, THE NUMBER WILL
ALWAYS BE 1.

2 DIGITS UNSIGNED

DB2 ALIAS: CLM_SGMT_NUM
SAS ALIAS: SGMT_NUM
STANDARD ALIAS: CLM_SGMT_NUM
TITLE ALIAS: SEGMENT_NUMBER

SOURCE:
CWF

24. CLAIM TOTAL LINE COUNT	NUM	3	129	131	EFFECTIVE WITH VERSION I, THE COUNT USED TO IDENTIFY THE TOTAL NUMBER OF REVENUE CENTER LINES ASSOCIATED WITH THE CLAIM.
----------------------------	-----	---	-----	-----	--

NOTE: DURING THE VERSION I CONVERSION THIS
FIELD WAS POPULATED WITH DATA THROUGHOUT
HISTORY (BACK TO SERVICE YEAR 1991).
PRIOR TO VERSION 'I', THE MAXIMUM LINE COUNT
WILL BE NO MORE THAN 58. EFFECTIVE WITH VERSI
'I', THE MAXIMUM LINE COUNT COULD BE 450.

3 DIGITS UNSIGNED

DB2 ALIAS: TOT_LINE_CNT
SAS ALIAS: LINECNT
STANDARD ALIAS: CLM_TOT_LINE_CNT
TITLE ALIAS: TOTAL_LINE_COUNT

SOURCE:
CWF

25. CLAIM SEGMENT LINE COUNT	NUM	2	132	133	EFFECTIVE WITH VERSION I, THE COUNT USED TO IDENTIFY THE NUMBER OF REVENUE CENTER LINES ON A RECORD/SEGMENT.
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NOTE: DURING THE VERSION I CONVERSION THIS
FIELD WAS POPULATED WITH DATA THROUGHOUT
HISTORY (BACK TO SERVICE YEAR 1991).
THE MAXIMUM LINE COUNT PER RECORD/SEGMENT

IS 45.

2 DIGITS UNSIGNED

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					DB2 ALIAS: SGMT_LINE_CNT SAS ALIAS: SGMTLINE STANDARD ALIAS: CLM_SGMT_LINE_CNT TITLE ALIAS: SEGMENT_LINE_COUNT SOURCE: CWF
**** FI CLAIM COMMON GROUP	GROUP	359	134	492	INFORMATION COMMON TO FISCAL INTERMEDIARY (FI) CLAIMS (INPATIENT/SNF, OUTPATIENT, HHA & HOSPICE), FOR VERSION I OF NCH NEARLINE FILE. STANDARD ALIAS: FI_CLM_CMN_GRP
26. NCH PAYMENT AND EDIT RECORD IDENTIFICATION CODE	CHAR	1	134	134	THE CODE USED FOR PAYMENT AND EDITING PURPOSES THAT INDICATES THE TYPE OF INSTITUTIONAL CLAIM RECORD. DB2 ALIAS: PMT_EDIT_RIC_CD SAS ALIAS: PE_RIC STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD TITLE ALIAS: NCH_PAYMENT_EDIT_RIC CODES: C = INPATIENT HOSPITAL, SNF D = OUTPATIENT E = RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS (EF CHRISTIAN SCIENCE, PRIOR TO 7/00 F = HOME HEALTH AGENCY (HHA) G = DISCHARGE NOTICE (OBSOLETE 7/98) I = HOSPICE COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: PMT_EDIT_RIC_CD.

SOURCE:
NCH QA PROCESS

27. CLAIM TRANSACTION CODE CHAR 1 135 135 THE CODE DERIVED BY CWF TO INDICATE THE TYPE OF CLAIM
SUBMITTED BY AN INSTITUTIONAL PROVIDER.

DB2 ALIAS: CLM_TRANS_CD
SAS ALIAS: TRANS_CD
STANDARD ALIAS: CLM_TRANS_CD
SYSTEM ALIAS: LTCLTRAN
TITLE ALIAS: TRANSACTION_CODE

CODES:
REFER TO: CLM_TRANS_TB
IN THE CODES APPENDIX

SOURCE:
CWF

**** CLAIM BILL TYPE GROUP GROUP 2 136 137 EFFECTIVE WITH VERSION H, THE CLAIM FACILITY TYPE COD
1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
-----	----	-----	-----	-----	-----	-----
						THE CLAIM SERVICE CLASSIFICATION TYPE CODE. (THE FIR POSITIONS OF THE ('TYPE OF BILL')). DURING THE VERSIO CONVERSION, THIS GROUPING WAS CREATED THROUGHOUT HIST

STANDARD ALIAS: CLM_BILL_TYPE_CD_GRP
SYSTEM ALIAS: LTBILLCD

CODES:
REFER TO: CLM_BILL_TYPE_TB
IN THE CODES APPENDIX

28. CLAIM FACILITY TYPE CODE CHAR 1 136 136 THE FIRST DIGIT OF THE TYPE OF BILL (TOB1) SUBMITTED
INSTITUTIONAL CLAIM USED TO IDENTIFY THE TYPE OF FACI
THAT PROVIDED CARE TO THE BENEFICIARY.

COMMON ALIAS: TOB1
DB2 ALIAS: CLM_FAC_TYPE_CD
SAS ALIAS: FAC_TYPE

STANDARD ALIAS: CLM_FAC_TYPE_CD
TITLE ALIAS: TOB1

CODES:

REFER TO: CLM_FAC_TYPE_TB
IN THE CODES APPENDIX

SOURCE:

CWF

29. CLAIM SERVICE CLASSIFICATION TYPE CODE	CHAR	1	137	137	THE SECOND DIGIT OF THE TYPE OF BILL (TOB2) SUBMITTED INSTITUTIONAL CLAIM RECORD TO INDICATE THE CLASSIFICA THE TYPE OF SERVICE PROVIDED TO THE BENEFICIARY.
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COMMON ALIAS: TOB2

DB2 ALIAS: SRVC_CLSFCTN_CD

SAS ALIAS: TYPESRVC

STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD

TITLE ALIAS: TOB2

CODES:

REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
IN THE CODES APPENDIX

SOURCE:

CWF

30. CLAIM FREQUENCY CODE	CHAR	1	138	138	THE THIRD DIGIT OF THE TYPE OF BILL (TOB3) SUBMITTED INSTITUTIONAL CLAIM RECORD TO INDICATE THE SEQUENCE O CLAIM IN THE BENEFICIARY'S CURRENT EPISODE OF CARE.
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COMMON ALIAS: TOB3

DB2 ALIAS: CLM_FREQ_CD

SAS ALIAS: FREQ_CD

STANDARD ALIAS: CLM_FREQ_CD

SYSTEM ALIAS: LTFREQ

TITLE ALIAS: FREQUENCY_CD

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
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CODES:

REFER TO: CLM_FREQ_TB
IN THE CODES APPENDIX

SOURCE:
CWF

31. FILLER CHAR 1 139 139

32. NCH MQA QUERY PATCH CODE CHAR 1 140 140

EFFECTIVE WITH VERSION H, A CODE USED (FOR INTERNAL E PURPOSES) TO INDICATE THAT THE CWFMQA PROCESS CHANGED QUERY CODE SUBMITTED ON THE CLAIM RECORD.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 FIELD WAS POPULATED WITH DATA. CLAIMS PROCESS PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS F

DB2 ALIAS: MQA_QUERY_PATCH_CD
SAS ALIAS: MQAQUERY
STANDARD ALIAS: NCH_MQA_QUERY_PATCH_CD
TITLE ALIAS: MQA_QUERY_PATCH_IND

CODES:

Y = MQA CHANGED BILL QUERY CODE ON A ACTION
CODE 6 (FORCE ACTION CODE 2)
BILL TO A ZERO. (EFF. 10/12/93)
Z = MQA CHANGED BILL QUERY CODE ON A ACTION
CODE 4 (CANCEL ONLY ADJUSTMENT)
BILL TO ZERO. (EFF. 5/16/94)

SOURCE:
NCH QA PROCESS

33. CLAIM DISPOSITION CODE CHAR 2 141 142

CODE INDICATING THE DISPOSITION OR OUTCOME OF THE PRO OF THE CLAIM RECORD.

DB2 ALIAS: CLM_DISP_CD
SAS ALIAS: DISP_CD
STANDARD ALIAS: CLM_DISP_CD
TITLE ALIAS: DISPOSITION_CD

CODES:

REFER TO: CLM_DISP_TB
IN THE CODES APPENDIX

SOURCE:

CWF

34. NCH EDIT DISPOSITION CODE CHAR 2 143 144 EFFECTIVE WITH VERSION H, A CODE USED (FOR INTERNAL E PURPOSES) TO INDICATE THE DISPOSITION OF THE CLAIM AF EDITING IN THE CWFMQA PROCESS.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSE TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
DB2 ALIAS: NCH_EDIT_DISP_CD						
SAS ALIAS: EDITDISP						
STANDARD ALIAS: NCH_EDIT_DISP_CD						
TITLE ALIAS: NCH_EDIT_DISP						
CODES:						
00 = NO MQA ERRORS						
10 = POSSIBLE DUPLICATE						
20 = UTILIZATION ERROR						
30 = CONSISTENCY ERROR						
40 = ENTITLEMENT ERROR						
50 = IDENTIFICATION ERROR						
60 = LOGICAL DUPLICATE						
70 = SYSTEMS DUPLICATE						
SOURCE:						
NCH QA PROCESS						
35. NCH CLAIM BIC MODIFY H CODE	CHAR	1	145	145		EFFECTIVE WITH VERSION H, THE CODE USED (FOR INTERNAL EDITING PURPOSES) TO IDENTIFY A CLAIM RECORD THAT WAS SUBMITTED WITH AN INCORRECT HA, HB, OR HC BIC.
NOTE:						BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 FIELD WAS POPULATED WITH DATA. CLAIMS PROCES PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS F
DB2 ALIAS: NCH_BIC_MDFY_CD						
SAS ALIAS: BIC_MDFY						

STANDARD ALIAS: NCH_CLM_BIC_MDFY_CD
TITLE ALIAS: BIC_MODIFY_CD

CODES:

H = BIC SUBMITTED BY CWF = HA, HB OR HC
BLANK = NO HA, HB OR HC BIC PRESENT

SOURCE:

NCH QA PROCESS

36. BENEFICIARY RESIDENCE SSA CHAR 3 146 148 THE SSA STANDARD COUNTY CODE OF A BENEFICIARY'S RESID
STANDARD COUNTY CODE

DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:

OPTIONAL: MAY BE BLANK

SOURCE:

SSA/EDB

37. FI CLAIM RECEIPT DATE NUM 8 149 156 THE DATE THE FISCAL INTERMEDIARY RECEIVED THE
INSTITUTIONAL CLAIM FROM THE PROVIDER.

8 DIGITS UNSIGNED

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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DB2 ALIAS: FI_CLM_RCPT_DT
SAS ALIAS: RCPT_DT
STANDARD ALIAS: FI_CLM_RCPT_DT
TITLE ALIAS: RECEIPT_DT

EDIT-RULES:

YYYYMMDD

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:

FICARR_CLM_RCPT_DT.

SOURCE:
CWF

38. FI CLAIM SCHEDULED PAYMENT DATE	NUM	8	157	164	THE SCHEDULED DATE OF PAYMENT TO THE INSTITU- TIONAL PROVIDER, AS REFLECTED ON THE CLAIM RECORD TRANSMITTED TO THE CWF HOST. NOTE: THIS DATE IS CONSIDERED TO BE THE DATE PAID SINCE NO ADDITIONAL INFORMATION AS TO THE ACTUAL PAYMENT DATE IS AVAILABLE.
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8 DIGITS UNSIGNED

DB2 ALIAS: FI_SCHLD_PMT_DT
SAS ALIAS: SCHLD_DT
STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT
TITLE ALIAS: SCHEDULED_PMT_DT

EDIT-RULES:
YYYYMMDD

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
FICARR_CLM_PMT_DT.

SOURCE:
CWF

39. CWF FORWARDED DATE	NUM	8	165	172	EFFECTIVE WITH VERSION H, THE DATE CWF FORWARDED THE RECORD TO HCFA (USED FOR INTERNAL EDITING PURPOSES).
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NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97
FIELD WAS POPULATED WITH DATA. CLAIMS PROCESS
PRIOR TO 10/3/97 WILL CONTAIN ZEROES IN THIS F

8 DIGITS UNSIGNED

DB2 ALIAS: CWF_FRWRD_DT
SAS ALIAS: FRWRD_DT
STANDARD ALIAS: CWF_FRWRD_DT
TITLE ALIAS: FORWARD_DT

EDIT-RULES:

9/3/2002

SOURCE:
CWF

42. CWF TRANSMISSION BATCH CHAR 4 186 189 EFFECTIVE WITH VERSION H, THE NUMBER ASSIGNED
NUMBER TO EACH BATCH OF CLAIMS TRANSACTIONS SENT FROM
CWF(USED FOR INTERNAL EDITING PURPOSES).

NOTE: BEGINNING 11/98, THIS FIELD WILL BE
POPULATED WITH DATA. CLAIMS PROCESSED
PRIOR TO 11/98 WILL CONTAIN SPACES IN
THIS FIELD.

DB2 ALIAS: TRNSMSN_BATCH_NUM
SAS ALIAS: FIBATCH
STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM
TITLE ALIAS: BATCH_NUM

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	CONTENTS
42. CWF TRANSMISSION BATCH NUMBER	CHAR	4	186	189	<p>SOURCE: CWF</p> <p>EFFECTIVE WITH VERSION H, THE NUMBER ASSIGNED TO EACH BATCH OF CLAIMS TRANSACTIONS SENT FROM CWF(USED FOR INTERNAL EDITING PURPOSES).</p> <p>NOTE: BEGINNING 11/98, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 11/98 WILL CONTAIN SPACES IN THIS FIELD.</p> <p>DB2 ALIAS: TRNSMSN_BATCH_NUM SAS ALIAS: FIBATCH STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM TITLE ALIAS: BATCH_NUM</p>
43. BENEFICIARY MAILING CONTACT ZIP CODE	CHAR	9	190	198	<p>THE ZIP CODE OF THE MAILING ADDRESS WHERE THE BENEFICIARY MAY BE CONTACTED.</p> <p>DB2 ALIAS: BENE_MLG_ZIP_CD SAS ALIAS: BENE_ZIP STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD TITLE ALIAS: BENE_ZIP</p> <p>SOURCE: EDB</p>
44. BENEFICIARY SEX IDENTIFICATION CODE	CHAR	1	199	199	<p>THE SEX OF A BENEFICIARY.</p> <p>COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD SAS ALIAS: SEX STANDARD ALIAS: BENE_SEX_IDENT_CD</p>

SOURCE:
SSA, RRB, EDB

SOURCE :
SSA

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
46. BENEFICIARY BIRTH DATE	NUM	8	201	208	THE BENEFICIARY'S DATE OF BIRTH.
					8 DIGITS UNSIGNED

CODES:
10 = AGED WITHOUT ESRD

11 = AGED WITH ESRD
 20 = DISABLED WITHOUT ESRD
 21 = DISABLED WITH ESRD
 31 = ESRD ONLY

COMMENT:
 PRIOR TO VERSION H THIS FIELD WAS NAMED:
 BENE_MDCR_STUS_CD. THE NAME HAS BEEN CHANGED

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					TO DISTINGUISH THIS CWF-DERIVED FIELD FROM THE EDB-DERIVED MSC (BENE_MDCR_STUS_CD).
					SOURCE: CWF
48. CLAIM PATIENT 6 POSITION SURNAME	CHAR	6	211	216	THE FIRST 6 POSITIONS OF THE MEDICARE PATIENT'S SURNAME (LAST NAME) AS REPORTED BY THE PROVIDER ON THE CLAIM.
					NOTE1: PRIOR TO VERSION H, THIS FIELD WAS ONLY PRESENT ON THE IP/SNF CLAIM RECORD. EFFECTIVE WITH VERSION H, THIS FIELD IS PRESENT ON ALL CLAIM TYPES.
					NOTE2: FOR OP, HHA, HOSPICE AND ALL CARRIER CLAIMS, DATA WAS POPULATED BEGINNING WITH NCH WEEKLY PROCESS 10/3/97. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.
					COMMON ALIAS: PATIENT_SURNAME DB2 ALIAS: PTNT_6_PSTN_SRNM SAS ALIAS: SURNAME STANDARD ALIAS: CLM_PTNT_6_PSTN_SRNM_NAME TITLE ALIAS: PATIENT_SURNAME
					SOURCE: CWF
49. CLAIM PATIENT 1ST INITIAL	CHAR	1	217	217	THE FIRST INITIAL OF THE MEDICARE PATIENT'S

GIVEN NAME

GIVEN NAME (FIRST NAME) AS REPORTED BY THE
PROVIDER ON THE CLAIM.NOTE1: PRIOR TO VERSION H, THIS FIELD WAS ONLY
PRESENT ON THE IP/SNF CLAIM RECORD.
EFFECTIVE WITH VERSION H, THIS FIELD
IS PRESENT ON ALL CLAIM TYPES.NOTE2: FOR OP, HHA, HOSPICE AND ALL CARRIER CLAIMS,
DATA WAS POPULATED BEGINNING WITH NCH
WEEKLY PROCESS DATE 10/3/97. CLAIMS
PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.COMMON ALIAS: PATIENT_GIVEN_NAME
DB2 ALIAS: 1ST_INITL_GVN_NAME
SAS ALIAS: FRSTINIT
STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME
TITLE ALIAS: PATIENT_FIRST_INITIALSOURCE:
CWF50. CLAIM PATIENT FIRST INITIAL CHAR 1 218 218 THE FIRST INITIAL OF THE MEDICARE PATIENT'S
MIDDLE NAME MIDDLE NAME AS REPORTED BY THE PROVIDER ON

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	-----	-----	-----
					THE CLAIM.

NOTE1: PRIOR TO VERSION H, THIS FIELD WAS ONLY
PRESENT ON THE IP/SNF CLAIM RECORD.
EFFECTIVE WITH VERSION H, THIS FIELD IS
PRESENT ON ALL CLAIM TYPES.NOTE2: FOR OP, HHA, HOSPICE AND ALL CARRIER CLAIMS,
DATA WAS POPULATED BEGINNING WITH NCH
WEEKLY PROCESS DATE 10/3/97. CLAIMS PRO-
CESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

COMMON ALIAS: PATIENT_MIDDLE_NAME

DB2 ALIAS: 1ST_INITL_MDL_NAME
 SAS ALIAS: MDL_INIT
 STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME
 TITLE ALIAS: PATIENT_MIDDLE_INITIAL

SOURCE:
 CWF

51. BENEFICIARY CWF LOCATION CODE	CHAR	1	219	219	THE CODE THAT IDENTIFIES THE COMMON WORKING FILE (CWF) LOCATION (THE HOST SITE) WHERE A BENEFICIARY'S MEDICARE UTILIZATION RECORDS ARE MAINTAINED.
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COMMON ALIAS: CWF_HOST
 DB2 ALIAS: BENE_CWF_LOC_CD
 SAS ALIAS: CWFLOCCD
 STANDARD ALIAS: BENE_CWF_LOC_CD
 SYSTEM ALIAS: LTCWFLOC
 TITLE ALIAS: CWF_HOST

CODES:
 B = MID-ATLANTIC
 C = SOUTHWEST
 D = NORTHEAST
 E = GREAT LAKES
 F = GREAT WESTERN
 G = KEYSTONE
 H = SOUTHEAST
 I = SOUTH
 J = PACIFIC

SOURCE:
 CWF

52. CLAIM PRINCIPAL DIAGNOSIS CODE	CHAR	5	220	224	THE ICD-9-CM DIAGNOSIS CODE IDENTIFYING THE DIAGNOSIS CONDITION, PROBLEM OR OTHER REASON FOR THE ADMISSION/ENCOUNTER/VISIT SHOWN IN THE MEDICAL RECORD CHIEFLY RESPONSIBLE FOR THE SERVICES PROVIDED.
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NOTE: EFFECTIVE WITH VERSION H, THIS DATA IS ALSO
 REDUNDANTLY STORED AS THE FIRST OCCURRENCE OF THE DIA
 TRAILER.

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					DB2 ALIAS: PRNCPAL_DGNS_CD SAS ALIAS: PDGNS_CD STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD TITLE ALIAS: PRINCIPAL_DIAGNOSIS EDIT-RULES: ICD-9-CM SOURCE: CWF
53. FILLER	CHAR	1	225	225	
54. CLAIM MEDICARE NON PAYMENT REASON CODE	CHAR	1	226	226	THE REASON THAT NO MEDICARE PAYMENT IS MADE FOR SERVICES ON AN INSTITUTIONAL CLAIM. NOTE: EFFECTIVE WITH VERSION I, THIS FIELD WAS PUT ON ALL INSTITUTIONAL CLAIM TYPES. PRIOR TO VERSION I, THIS FIELD WAS PRESENT ONLY ON INPATIENT/SNF CLAIMS. DB2 ALIAS: MDCR_NPMT_RSN_CD SAS ALIAS: NOPAY_CD STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD SYSTEM ALIAS: LTNPMT TITLE ALIAS: NON_PAYMENT_REASON EDIT-RULES: OPTIONAL CODES: REFER TO: CLM_MDCR_NPMT_RSN_TB IN THE CODES APPENDIX SOURCE: CWF
55. CLAIM EXCEPTED/NONEXCEPTED MEDICAL TREATMENT CODE	CHAR	1	227	227	EFFECTIVE WITH VERSION I, THE CODE USED TO IDENTIFY WHETHER OR NOT THE MEDICAL CARE OR TREATMENT RECEIVED BY A BENEFICIARY, WHO HAS ELECTED CARE FROM A RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION (RNHCI),

IS EXCEPTED OR NONEXCEPTED. EXCEPTED IS MEDICAL CARE OR TREATMENT THAT IS RECEIVED INVOLUNTARILY OR IS REQUIRED UNDER FEDERAL, STATE OR LOCAL LAW. NONEXCEPTED DEFINED AS MEDICAL CARE OR TREATMENT OTHER THAN EXCEP

DB2 ALIAS: EXCPTD_NEXCPTD_CD
SAS ALIAS: TRTMT_CD
STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD
TITLE ALIAS: EXCPTD_NEXCPTD_CD

CODES:
0 = NO ENTRY
1 = EXCEPTED
2 = NONEXCEPTED

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
56. CLAIM PAYMENT AMOUNT	PACK	6	228	233	<p>SOURCE: CWF</p> <p>AMOUNT OF PAYMENT MADE FROM THE MEDICARE TRUST FUND F SERVICES COVERED BY THE CLAIM RECORD. GENERALLY, THE IS CALCULATED BY THE FI OR CARRIER; AND REPRESENTS WH PAID TO THE INSTITUTIONAL PROVIDER, PHYSICIAN, OR SUP WITH THE EXCEPTIONS NOTED BELOW. **NOTE: IN SOME SITUATIONS, A NEGATIVE CLAIM PAYMENT AMOUNT MAY BE PR SENT; E.G., (1) WHEN A BENEFICIARY IS CHARGED THE FUL DEDUCTIBLE DURING A SHORT STAY AND THE DEDUCTIBLE EXC THE AMOUNT MEDICARE PAYS; OR (2) WHEN A BENEFICIARY I CHARGED A COINSURANCE AMOUNT DURING A LONG STAY AND T COINSURANCE AMOUNT EXCEEDS THE AMOUNT MEDICARE PAYS (. PREVALENT SITUATION INVOLVES PSYCH HOSPITALS WHO ARE DAILY PER DIEM RATE NO MATTER WHAT THE CHARGES ARE.)</p> <p>UNDER IP PPS, INPATIENT HOSPITAL SERVICES ARE PAID BA A PREDETERMINED RATE PER DISCHARGE, USING THE DRG PAT CLASSIFICATION SYSTEM AND THE PRICER PROGRAM. ON TH PPS CLAIM, THE PAYMENT AMOUNT INCLUDES THE DRG OUTLIE APPROVED PAYMENT AMOUNT, DISPROPORTIONATE SHARE (SINC 5/1/86), INDIRECT MEDICAL EDUCATION (SINCE 10/1/88), PPS CAPITAL (SINCE 10/1/91). IT DOES NOT INCLUDE THE</p>

THRU AMOUNTS (I.E., CAPITAL-RELATED COSTS, DIRECT MED EDUCATION COSTS, KIDNEY ACQUISITION COSTS, BAD DEBTS) ANY BENEFICIARY-PAID AMOUNTS (I.E., DEDUCTIBLES AND COINSURANCE); OR ANY OTHER PAYER REIMBURSEMENT.

UNDER SNF PPS, SNFS WILL CLASSIFY BENEFICIARIES USING PATIENT CLASSIFICATION SYSTEM KNOWN AS RUGS III. FOR SNF PPS CLAIM, THE SNF PRICER WILL CALCULATE/RETURN T FOR EACH REVENUE CENTER LINE ITEM WITH REVENUE CENTER '0022'; MULTIPLY THE RATE TIMES THE UNITS COUNT; AND SUM THE AMOUNT PAYABLE FOR ALL LINES WITH REVENUE CEN CODE '0022' TO DETERMINE THE TOTAL CLAIM PAYMENT AMOU

UNDER OUTPATIENT PPS, THE NATIONAL AMBULATORY PAYMENT CLASSIFICATION (APC) RATE THAT IS CALCULATED FOR EACH GROUP IS THE BASIS FOR DETERMINING THE TOTAL PAYMENT. MEDICARE PAYMENT AMOUNT TAKES INTO ACCOUNT THE WAGE I ADJUSTMENT AND THE BENEFICIARY DEDUCTIBLE AND COINSUR AMOUNTS. NOTE: THERE IS NO CWF EDIT CHECK TO VALIDAT THE REVENUE CENTER MEDICARE PAYMENT AMOUNT EQUALS THE LEVEL MEDICARE PAYMENT AMOUNT.

UNDER HOME HEALTH PPS, BENEFICIARIES WILL BE CLASSIFI AN APPROPRIATE CASE MIX CATEGORY KNOWN AS THE HOME HE RESOURCE GROUP. A HIPPS CODE IS THEN GENERATED CORRESPONDING TO THE CASE MIX CATEGORY (HHRG).

FOR THE RAP, THE PRICER WILL DETERMINE THE PAYMENT AM APPROPRIATE TO THE HIPPS CODE BY COMPUTING 60% (FOR F EPISODE) OR 50% (FOR SUBSEQUENT EPISODES) OF THE CASE EPISODE PAYMENT. THE PAYMENT IS THEN WAGE INDEX ADJU

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					FOR THE FINAL CLAIM, PRICER CALCULATES 100% OF THE AM DUE, BECAUSE THE FINAL CLAIM IS PROCESSED AS AN ADJUS TO THE RAP, REVERSING THE RAP PAYMENT IN FULL. ALTHO FINAL CLAIM WILL SHOW 100% PAYMENT AMOUNT, THE PROVID ACTUALLY RECEIVE THE 40% OR 50% PAYMENT.

EXCEPTIONS: FOR CLAIMS INVOLVING DEMOS AND BBA ENCOU

DATA, THE AMOUNT REPORTED IN THIS FIELD MAY NOT JUST REPRESENT THE ACTUAL PROVIDER PAYMENT.

FOR DEMO IDS '01','02','03','04' -- CLAIMS CONTAIN AMOUNT PAID TO THE PROVIDER, EXCEPT THAT SPECIAL 'DIFFERENTIALS' PAID OUTSIDE THE NORMAL PAYMENT ARE NOT INCLUDED.

FOR DEMO IDS '05','15' -- ENCOUNTER DATA 'CLAIMS' CONTAIN AMOUNT MEDICARE WOULD HAVE PAID UNDER FF INSTEAD OF THE ACTUAL PAYMENT TO THE MCO.

FOR DEMO IDS '06','07','08' -- CLAIMS CONTAIN AC PROVIDER PAYMENT BUT REPRESENT A SPECIAL NEGOTIATED BUNDLED PAYMENT FOR BOTH PART A AND PART B SERVICES TO IDENTIFY WHAT THE CONVENTIONAL PROVIDER PART B PAYMENT WOULD HAVE BEEN, CHECK VALUE CODE = 'Y4' RELATED NONINSTITUTIONAL (PHYSICIAN/SUPPLIER) CLAIMS CONTAIN WHAT WOULD HAVE BEEN PAID HAD THERE BEEN A DEMO.

FOR BBA ENCOUNTER DATA (NON-DEMO) -- 'CLAIMS' CONTAIN AMOUNT MEDICARE WOULD HAVE PAID UNDER FFS, INSTEAD OF THE ACTUAL PAYMENT TO THE BBA PLAN.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: CLM_PMT_AMT
SAS ALIAS: PMT_AMT
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
\$\$\$\$\$\$\$\$\$CC

COMMENT:
PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS S9(7)V9. THE NONINSTITUTIONAL CLAIM RECORDS CARRIED THIS FIELD ITEM. EFFECTIVE WITH VERSION H, THIS ELEMENT IS A CLAIMS FIELD ACROSS ALL CLAIM TYPES (AND THE LINE ITEM FIELD RENAMED.)

SOURCE:

CWF

LIMITATIONS:

PRIOR TO 4/6/93, ON INPATIENT, OUTPATIENT, AND

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
57. NCH PRIMARY PAYER CLAIM PAID AMOUNT	PACK	6	234	239	PHYSICIAN/SUPPLIER CLAIMS CONTAINING A CLM_DISP_CD OF '02', THE AMOUNT SHOWN AS THE MEDICARE REIMBURSEMENT DOES NOT TAKE INTO CONSIDERATION ANY CWF AUTOMATIC ADJUSTMENTS (INVOLVING ERRONEOUS DEDUCTIBLES IN MOST CASES). IN AS MANY AS 30% OF THE CLAIMS (30% IP, 15% OP, 5% PART B), THE REIMBURSEMENT REPORTED ON THE CLAIMS MAY BE OVER OR UNDER THE ACTUAL MEDICARE PAYMENT AMOUNT. THE AMOUNT OF A PAYMENT MADE ON BEHALF OF A MEDICARE BENEFICIARY BY A PRIMARY PAYER OTHER THAN MEDICARE, T PROVIDER IS APPLYING TO COVERED MEDICARE CHARGES ON A INSTITUTIONAL, CARRIER, OR DMERC CLAIM. 9.2 DIGITS SIGNED DB2 ALIAS: PRMRY_PYR_PD_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT EDIT-RULES: \$\$\$\$\$\$\$\$\$CC COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: BENE_PRMRY_PYR_CLM_PMT_AMT AND THE FIELD SIZE WAS S9(7)V99. SOURCE: NCH
58. NCH PRIMARY PAYER CODE	CHAR	1	240	240	THE CODE, ON AN INSTITUTIONAL CLAIM, SPECIFYING A FED NON-MEDICARE PROGRAM OR OTHER SOURCE THAT HAS PRIMARY

RESPONSIBILITY FOR THE PAYMENT OF THE MEDICARE BENEFIT
HEALTH INSURANCE BILLS.

DB2 ALIAS: NCH_PRMRY_PYR_CD
SAS ALIAS: PRPAY_CD
STANDARD ALIAS: NCH_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD

DERIVATION:
DERIVED FROM:
 CLM_VAL_CD
 CLM_VAL_AMT

DERIVATION RULES

SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE
CLM_VAL_CD = '12'

SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE
CLM_VAL_CD = '13'

SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE
CLM_VAL_CD = '14'

1

FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

					CLM_VAL_CD = '16' AND CLM_VAL_AMT IS ZEROES
					SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14'
					SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15'
					SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT NOT EQUAL TO ZEROES)
					SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43'
					SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM VAL_CD = '41'

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
...

DB2 ALIAS: FI_CLM_ACTN_CD
SAS ALIAS: ACTIONCD
STANDARD ALIAS: FI_CLM_ACTN_CD
TITLE ALIAS: ACTION_CD

CODES:

REFER TO: FI_CLM_ACTN_TB
IN THE CODES APPENDIX

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:
INTRMDRY_CLM_ACTN_CD.

SOURCE:

CWF

61. FI CLAIM PROCESS DATE	NUM	8	243	250	THE DATE THE FISCAL INTERMEDIARY COMPLETES PROCESSING AND RELEASES THE INSTITUTIONAL CLAIM TO THE CWF HOST.
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8 DIGITS UNSIGNED

DB2 ALIAS: FI_CLM_PROC_DT
SAS ALIAS: APRVL_DT
STANDARD ALIAS: FI_CLM_PROC_DT
TITLE ALIAS: FI_PROCESS_DT

EDIT-RULES:

YYYYMMDD

SOURCE:

CWF

62. NCH PROVIDER STATE CODE	CHAR	2	251	252	EFFECTIVE WITH VERSION H, THE TWO POSITION SSA STATE WHERE PROVIDER FACILITY IS LOCATED.
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NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS
POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVI
1991).

DB2 ALIAS: NCH_PRVDR_STATE_CD
SAS ALIAS: PRSTATE
STANDARD ALIAS: NCH_PRVDR_STATE_CD

TITLE ALIAS: PROVIDER_STATE_CD

DERIVATION:

DERIVED FROM:

NCH PRVDR_NUM

DERIVATION RULES:

SET NCH_PRVDR_STATE_CD TO
PRVDR_NUM POS1-2.

FOR PRVDR_NUM POS1-2 EQUAL '55

SET NCH_PRVDR_STATE_CD TO '05'.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					FOR PRVDR_NUM POS1-2 EQUAL '67 SET NCH_PRVDR_STATE_CD TO '45'. FOR PRVDR_NUM POS1-2 EQUAL '68 SET NCH_PRVDR_STATE_CD TO '10'. CODES: REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX SOURCE: NCH
ORGANIZATION NPI NUMBER	CHAR	10	253	262	A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H) FOR ST THE NPI ASSIGNED TO THE INSTITUTIONAL PROVIDER. DB2 ALIAS: ORG_NPI_NUM SAS ALIAS: ORGNPINM STANDARD ALIAS: ORG_NPI_NUM TITLE ALIAS: ORG_NPI SOURCE: CWF
ATTENDING PHYSICIAN ID GROUP	GROUP	24	263	286	NAME AND IDENTIFICATION NUMBERS ASSOCIATED WITH THE PRIMARY CARE PHYSICIAN. STANDARD ALIAS: ATNDG_PHYSN_ID_GRP

64. CLAIM ATTENDING PHYSICIAN CHAR 6 263 268 ON AN INSTITUTIONAL CLAIM, THE UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN) OF THE PHYSICIAN WHO WOULD NORMALLY BE EXPECTED TO CERTIFY AND RECERTIFY THE MEDICAL NECESSITY OF THE SERVICES RENDERED AND/OR WHO HAS PRIMARY RESPONSIBILITY FOR THE BENEFICIARY'S MEDICAL CARE AND TREATMENT (ATTENDING PHYSICIAN).

COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
DB2 ALIAS: ATNDG_UPIN
SAS ALIAS: AT_UPIN
STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
TITLE ALIAS: ATTENDING_PHYSICIAN

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_PRMRY_CARE_PHYSN_IDENT_NUM AND CONTAINED
10 POSITIONS (6-POSITION UPIN AND 4-POSITION
PHYSICIAN SURNAME).

SOURCE:
CWF

65. CLAIM ATTENDING PHYSICIAN CHAR 10 269 278 A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H) FOR STORING THE NPI ASSIGNED TO THE ATTENDING PHYSICIAN.

COMMON ALIAS: ATTENDING_PHYSICIAN_NPI

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
-----	----	-----	-----	-----
				DB2 ALIAS: ATNDG_NPI
				SAS ALIAS: AT_NPI
				STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM
				TITLE ALIAS: ATNDG_NPI

SOURCE:
CWF

66. CLAIM ATTENDING PHYSICIAN CHAR 6 279 284 EFFECTIVE WITH VERSION H, THE LAST NAME OF THE ATTENDING PHYSICIAN (USED FOR INTERNAL EDITING SURNAME)

PURPOSE IN HCFA'S CWFMQA SYSTEM.)

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: ATNDG_SRNM
SAS ALIAS: AT_SRNM
STANDARD ALIAS: CLM_ATNDG_PHYSN_SRNM_NAME
TITLE ALIAS: ANDG_PHYSN_SURNAME

SOURCE:
CWF

67. CLAIM ATTENDING PHYSICIAN GIVEN NAME	CHAR	1	285	285	EFFECTIVE WITH VERSION H, THE FIRST NAME OF THE ATTENDING PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM).
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NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: ATNDG_GVN_NAME
SAS ALIAS: AT_GVNNM
STANDARD ALIAS: CLM_ATNDG_PHYSN_GVN_NAME
TITLE ALIAS: ATNDG_PHYSN_FIRSTNAME

SOURCE:
CWF

68. CLAIM ATTENDING PHYSICIAN MIDDLE INITIAL NAME	CHAR	1	286	286	EFFECTIVE WITH VERSION H, THE MIDDLE INITIAL OF THE ATTENDING PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)
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NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: ATNDG_MI_NAME
SAS ALIAS: AT_MDL
STANDARD ALIAS: CLM_ATNDG_PHYSN_MDL_INITL_NAME

TITLE ALIAS: ATNDG_PHYSN_MI

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

	NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
							SOURCE: CWF
****	OPERATING PHYSICIAN ID GROUP	GROUP	24	287	310		NAME AND IDENTIFICATION NUMBERS ASSOCIATED WITH THE PHYSICIAN WHO PERFORMED THE PRINCIPAL PROCEDURE. STANDARD ALIAS: OPRTG_PHYSN_ID_GRP
69.	CLAIM OPERATING PHYSICIAN UPIN NUMBER	CHAR	6	287	292		ON AN INSTITUTIONAL CLAIM, THE UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN) OF THE PHYSICIAN WHO PERFORMED THE PRINCIPAL PROCEDURE. THIS ELEMENT IS USED BY THE PROVIDER TO IDENTIFY THE OPERATING PHYSICIAN WHO PERFORMED THE SURGICAL PROCEDURE. DB2 ALIAS: OPRTG_UPIN SAS ALIAS: OP_UPIN STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM TITLE ALIAS: OPRTG_UPIN COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_PRNCPAL_PRCDR_PHYSN_NUM AND CONTAINED 10 POSITIONS (6-POSITION UPIN AND 4-POSITION PHYSICIAN SURNAME. NOTE: FOR HHA AND HOSPICE FORMATS BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. HHA AND HOSPICE CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES. SOURCE: CWF
70.	CLAIM OPERATING PHYSICIAN NPI NUMBER	CHAR	10	293	302		A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H) FOR STORING THE NPI ASSIGNED TO THE OPERATING

PHYSICIAN.

DB2 ALIAS: OPRTG_NPI
SAS ALIAS: OP_NPI
STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM
TITLE ALIAS: OPRTG_NPI

SOURCE:
CWF

71. CLAIM OPERATING PHYSICIAN Surname CHAR 6 303 308 EFFECTIVE WITH VERSION H, THE LAST NAME OF THE OPERATING PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)

NOTE: BEGINNING WITH THE NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
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						DB2 ALIAS: OPRTG_SRNM SAS ALIAS: OP_SRNM STANDARD ALIAS: CLM_OPRTG_PHYSN_SRNM_NAME TITLE ALIAS: OPRTG_PHYSN_SURNAME SOURCE: CWF
72. CLAIM OPERATING PHYSICIAN GIVEN NAME	CHAR	1	309	309		EFFECTIVE WITH VERSION H, THE FIRST NAME OF THE OPERATING PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.) NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD. DB2 ALIAS: OPRTG_GVN_NAME SAS ALIAS: OP_GVN STANDARD ALIAS: CLM_OPRTG_PHYSN_GVN_NAME

TITLE ALIAS: OPRTG_PHYSN_FIRSTNAME

SOURCE:
CWF

73. CLAIM OPERATING PHYSICIAN MIDDLE INITIAL NAME CHAR 1 310 310 EFFECTIVE WITH VERSION H, THE MIDDLE INITIAL OF THE OPERATING PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.

DB2 ALIAS: OPRTG_MI_NAME
SAS ALIAS: OP_MDL
STANDARD ALIAS: CLM_OPRTG_PHYSN_MDL_INITL_NAME
TITLE ALIAS: OPRTG_PHYSN_MI

SOURCE:
CWF

**** OTHER PHYSICIAN ID GROUP GROUP 24 311 334 NAME AND IDENTIFICATION NUMBERS ASSOCIATED WITH THE O PHYSICIAN.

STANDARD ALIAS: OTHR_PHYSN_ID_GRP

74. CLAIM OTHER PHYSICIAN UPIN NUMBER CHAR 6 311 316 ON AN INSTITUTIONAL CLAIM, THE UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN) OF THE OTHER PHYSICIAN ASSOCIATED WITH THE INSTITUTIONAL CLAIM.

DB2 ALIAS: OTHR_UPIN
SAS ALIAS: OT_UPIN
STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
TITLE ALIAS: OTH_PHYSN_UPIN

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
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COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:

CLM_OTHR_PHYSN_IDENT_NUM AND CONTAINED
10 POSITIONS (6-POSITION UPIN AND 4-POSITION
OTHER PHYSICIAN SURNAME).

NOTE: FOR HHA AND HOSPICE FORMATS BEGINNING
WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD
WAS POPULATED WITH DATA. HHA AND HOSPICE CLAIMS
PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES.

SOURCE:
CWF

75. CLAIM OTHER PHYSICIAN NPI NUMBER	CHAR	10	317	326	A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H FOR STORING THE NPI ASSIGNED TO THE OTHER PHYSICIAN.
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DB2 ALIAS: OTHR_NPI
SAS ALIAS: OT_NPI
STANDARD ALIAS: CLM_OTHR_PHYSN_NPI_NUM

SOURCE:
CWF

76. CLAIM OTHER PHYSICIAN SURNAME	CHAR	6	327	332	EFFECTIVE WITH VERSION H, THE LAST NAME OF THE OTHER PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)
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NOTE: BEGINNING WITH THE NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: OTHR_SRNM
SAS ALIAS: OT_SRNM
STANDARD ALIAS: CLM_OTHR_PHYSN_SRNM_NAME
TITLE ALIAS: OTH_PHYSN_SURNAME

SOURCE:
CWF

77. CLAIM OTHER PHYSICIAN GIVEN NAME	CHAR	1	333	333	EFFECTIVE WITH VERSION H, THE FIRST NAME OF THE OTHER PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.)
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NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: OTHR_GVN_NAME
SAS ALIAS: OT_GVN
STANDARD ALIAS: CLM_OTHR_PHYSN_GVN_NAME
TITLE ALIAS: OTH_PHYSN_FIRSTNAME

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

					SOURCE: CWF
78. CLAIM OTHER PHYSICIAN MIDDLE INITIAL NAME	CHAR	1	334	334	EFFECTIVE WITH VERSION H, THE MIDDLE INITIAL OF THE OTHER PHYSICIAN (USED FOR INTERNAL EDITING PURPOSES IN HCFA'S CWFMQA SYSTEM.) NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD. DB2 ALIAS: OTHR_MI_NAME SAS ALIAS: OT_MDL STANDARD ALIAS: CLM_OTHR_PHYSN_MDL_INITL_NAME TITLE ALIAS: OTH_PHYSN_MI SOURCE: CWF
79. MEDICAID PROVIDER IDENTIFICATION NUMBER	CHAR	13	335	347	A UNIQUE IDENTIFICATION NUMBER ASSIGNED TO EACH PROVI THE STATE MEDICAID AGENCY. THIS UNIQUE PROVIDER NUMB USED TO ENSURE PROPER PAYMENT OF PROVIDERS AND TO MAI CLAIMS HISTORY ON INDIVIDUAL PROVIDERS FOR SURVEILLAN UTILIZATION REVIEW. DB2 ALIAS: MDCD_PRVDR_NUM SAS ALIAS: MDCD_PRV STANDARD ALIAS: MDCD_PRVDR_IDENT_NUM

CWF

82. CLAIM TREATMENT
AUTHORIZATION NUMBER

CHAR

18

353

370

THE NUMBER ASSIGNED BY THE MEDICAL REVIEWER AND REPORTED BY THE PROVIDER TO IDENTIFY THE MEDICAL REVIEW (TREATMENT AUTHORIZATION) ACTION TAKEN AFTER REVIEW OF THE BENEFICIARY'S CASE. IT DESIGNATES THAT TREATMENT COVERED BY THE BILL HAS BEEN AUTHORIZED BY THE PAYER. THIS NUMBER IS USED BY THE INTERMEDIARY AND THE PEER REVIEW ORGANIZATION.

NOTE: UNDER HH PPS THIS FIELD WILL BE USED TO LINK CLAIMS TO THE OASIS ASSESSMENT USED AS THE BASIS OF PAYMENT. THIS EIGHTEEN CHARACTER STRING CONSISTS OF THE START OF CARE DATE, THE OASIS ASSESSMENT DATE AND THE TWO DIGIT REASON FOR ASSESSMENT CODE.

COMMON ALIAS: TAN

DB2 ALIAS: TRTMT_AUTHRZTN_NUM

SAS ALIAS: AUTHRZTN

STANDARD ALIAS: CLM_TRTMT_AUTHRZTN_NUM

TITLE ALIAS: TREATMENT_AUTHORIZATION

SOURCE:

CWF

83. PATIENT CONTROL NUMBER

CHAR

20

371

390

THE UNIQUE ALPHANUMERIC IDENTIFIER ASSIGNED BY THE PROVIDER TO THE INSTITUTIONAL CLAIM TO FACILITATE RETRIEVAL OF INDIVIDUAL CASE RECORDS AND POSTING OF PAYMENTS.

DB2 ALIAS: PTNT_CNTL_NUM

SAS ALIAS: PTNTCNTL

STANDARD ALIAS: PTNT_CNTL_NUM

TITLE ALIAS: PATIENT_CONTROL_NUM

SOURCE:

CWF

84. CLAIM MEDICAL RECORD NUMBER

CHAR

17

391

407

THE NUMBER ASSIGNED BY THE PROVIDER TO THE BENEFICIARY'S MEDICAL RECORD TO ASSIST IN RECORD RETRIEVAL.

1

FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					DB2 ALIAS: CLM_MDCL_REC_NUM SAS ALIAS: MDCL_REC STANDARD ALIAS: CLM_MDCL_REC_NUM TITLE ALIAS: MEDICAL_RECORD_NUM SOURCE: CWF
85. CLAIM PRO CONTROL NUMBER	CHAR	12	408	419	EFFECTIVE WITH VERSION G, THE UNIQUE IDENTIFIER ASSIGNED BY THE PEER REVIEW ORGANIZATION (PRO) FOR CONTROL PURPOSES. DB2 ALIAS: CLM_PRO_CNTL_NUM SAS ALIAS: PRO_CNTL STANDARD ALIAS: CLM_PRO_CNTL_NUM TITLE ALIAS: PRO_CONTROL_NUM SOURCE: CWF
86. CLAIM PRO PROCESS DATE	NUM	8	420	427	EFFECTIVE WITH VERSION H, THE DATE THE CLAIM WAS USED IN THE PRO REVIEW PROCESS. NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN ZEROES IN THIS FIELD. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_PRO_PROC_DT SAS ALIAS: PRO_DT STANDARD ALIAS: CLM_PRO_PROC_DT TITLE ALIAS: PRO_PRO_C_DT EDIT-RULES: YYYYMMDD SOURCE:

CWF

87. PATIENT DISCHARGE STATUS
CODE

CHAR

2

428

429

THE CODE USED TO IDENTIFY THE STATUS OF THE
PATIENT AS OF THE CLM_THRU_DT.

COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
DB2 ALIAS: PTNT_DSCHRG_STUS
SAS ALIAS: STUS_CD
STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
SYSTEM ALIAS: LTCLMST
TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:

REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_STUS_CD.
					SOURCE: CWF
88. CLAIM DIAGNOSIS E CODE	CHAR	5	430	434	EFFECTIVE WITH VERSION H, THE ICD-9-CM CODE USED TO IDENTIFY THE EXTERNAL CAUSE OF INJURY, POISONING, OR OTHER ADVERSE AFFECT. REDUNDANTLY THIS FIELD IS ALSO STORED AS THE LAST OCCURRENCE OF THE DIAGNOSIS TRAILER.
					NOTE: DURING THE VERSION H CONVERSION, THE DATA IN THE LAST OCCURRENCE OF THE DIAGNOSIS TRAILER WAS USED TO POPULATE HISTORY.
					DB2 ALIAS: CLM_DGNS_E_CD SAS ALIAS: DGNS_E STANDARD ALIAS: CLM_DGNS_E_CD TITLE ALIAS: DGNS_E_CD
					SOURCE:

CWF

89. FILLER CHAR 1 435 435

90. CLAIM PPS INDICATOR CODE CHAR 1 436 436

EFFECTIVE WITH VERSION H, THE CODE INDICATING WHETHER OR NOT THE (1) CLAIM IS PPS AND/OR (2) THE BENEFICIARY IS A DEEMED INSURED MEDICARE QUALIFIED GOVERNMENT EMPLOYEE (MQGE) .

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THROUGH 5/29/98, THIS FIELD WAS POPULATED WITH ONLY THE PPS INDICATOR. BEGINNING WITH NCH WEEKLY PROCESS DATE 6/5/98, THIS FIELD WAS ADDITIONALLY POPULATED WITH THE DEEMED MQGE INDICATOR. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES.

COBOL ALIAS: PPS_IND
DB2 ALIAS: CLM_PPS_IND_CD
SAS ALIAS: PPS_IND
STANDARD ALIAS: CLM_PPS_IND_CD
TITLE ALIAS: PPS_IND

CODES:

REFER TO: CLM_PPS_IND_TB
IN THE CODES APPENDIX

SOURCE:

CWF

91. CLAIM TOTAL CHARGE AMOUNT PACK 6 437 442

EFFECTIVE WITH VERSION G, THE TOTAL CHARGES FOR ALL SERVICES INCLUDED ON THE INSTITUTIONAL CLAIM. THIS FIELD IS REDUNDANT WITH REVENUE CENTER

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
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				CODE 0001/TOTAL CHARGES.
				9.2 DIGITS SIGNED
				DB2 ALIAS: CLM_TOT_CHRG_AMT
				SAS ALIAS: TOT_CHRG

STANDARD ALIAS: CLM_TOT_CHRG_AMT
TITLE ALIAS: CLAIM_TOTAL_CHARGES

COMMENT:
PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS
S9(7)V99.

SOURCE:
CWF

92. FILLER CHAR 50 443 492

93. INPATIENT/SNF NCH EDIT CODE NUM 2 493 494 THE COUNT OF THE NUMBER OF EDIT CODES
COUNT ANNOTATED TO THE INPATIENT/SNF CLAIM
DURING THE HCFA'S CWFMQA PROCESS.
THE PURPOSE OF THIS COUNT IS TO INDICATE
HOW MANY CLAIM EDIT TRAILERS ARE PRESENT.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_NCH_EDIT_CD_CNT
SAS ALIAS: IPEDCNT
STANDARD ALIAS: IP_NCH_EDIT_CD_CNT

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_EDIT_CD_CNT.

SOURCE:
NCH

94. INPATIENT/SNF NCH PATCH NUM 2 495 496 EFFECTIVE WITH VERSION H, THE COUNT OF THE
CODE COUNT NUMBER OF HCFA PATCH CODES ANNOTATED TO THE
INPATIENT/SNF CLAIM DURING THE NEARLINE
MAINTENANCE PROCESS. THE PURPOSE OF THIS
COUNT IS TO INDICATE HOW MANY NCH PATCH
TRAILERS ARE PRESENT.

NOTE1: DURING THE VERSION H CONVERSION THIS
FIELD WAS POPULATED WITH DATA THROUGHOUT
HISTORY (BACK TO SERVICE YEAR 1991).

NOTE2: EFFECTIVE WITH VERSION 'I' THE NUMBER
OF POSSIBLE OCCURRENCES WAS REDUCED TO 30.

PRIOR TO VERSION 'I' THE NUMBER OF POSSIBLE
OCCURRENCES WAS 99).

2 DIGITS UNSIGNED

DB2 ALIAS: IP_PATCH_CD_CNT

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
95. INPATIENT/SNF MCO PERIOD COUNT	NUM	1	497	497	<p>SAS ALIAS: IPPATCNT STANDARD ALIAS: IP_NCH_PATCH_CD_I_CNT</p> <p>SOURCE: NCH</p> <p>EFFECTIVE WITH VERSION H, THE COUNT OF THE NUMBER OF CARE ORGANIZATION (MCO) PERIODS REPORTED ON AN INPATI CLAIM. THE PURPOSE OF THIS COUNT IS TO INDICATE HOW MCO PERIOD TRAILERS ARE PRESENT.</p> <p>NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIO 10/3/97 WILL CONTAIN ZEROES IN THIS FIELD.</p> <p>1 DIGIT UNSIGNED</p> <p>DB2 ALIAS: IP_MCO_PRD_CNT SAS ALIAS: IPMCOCNT STANDARD ALIAS: IP_MCO_PRD_CNT</p> <p>EDIT-RULES: RANGE: 0 TO 2</p> <p>SOURCE: NCH</p>
96. INPATIENT/SNF CLAIM HEALTH PLANID COUNT	NUM	1	498	498	<p>A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H) FOR STORING THE COUNT OF THE NUMBER OF HEALTH PLANIDS REPORTED ON THE INPATIENT/SNF CLAIM. THE PURPOSE OF THIS COUNT IS TO INDICATE HOW MANY HEALTH PLANID TRAILERS ARE PRESENT. NOTE: PRIOR TO VERSION 'I' THIS FIELD WAS NAMED:</p>

IP_CLM_PAYERID_CNT.

1 DIGIT UNSIGNED

DB2 ALIAS: IP_CLM_PLANID_CNT

SAS ALIAS: IPPLANID

STANDARD ALIAS: IP_CLM_HLTH_PLANID_CNT

EDIT-RULES:

RANGE: 0 TO 3

COMMENT:

PRIOR TO VERSION I THIS FIELD WAS NAMED:

IP_CLM_PAYERID_CNT.

SOURCE:

NCH

97. BEF INPATIENT/SNF CLAIM DEMONSTRATION ID COUNT NUM 1 499 499 THIS FIELD IS BLANK ON THE BENEFICIARY ENCRYPTED FILE

1 DIGIT UNSIGNED

DB2 ALIAS: BEF_IP_CLM_DEMO_ID

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
98. INPATIENT/SNF CLAIM DIAGNOSIS CODE COUNT	NUM	2	500	501	<p>THE COUNT OF THE NUMBER OF DIAGNOSIS CODES (BOTH PRIN AND OTHER) REPORTED ON AN INPATIENT/SNF CLAIM. THE P OF THIS COUNT IS TO INDICATE HOW MANY CLAIM DIAGNOSIS TRAILERS ARE PRESENT.</p> <p>2 DIGITS UNSIGNED</p> <p>DB2 ALIAS: IP_CLM_DGNS_CD_CNT</p> <p>SAS ALIAS: IPDGNCNT</p> <p>STANDARD ALIAS: IP_CLM_DGNS_CD_CNT</p> <p>EDIT-RULES:</p> <p>RANGE: 0 TO 10</p>

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_OTHR_DGNS_CD_CNT AND THE PRINCIPAL WAS
NOT INCLUDED IN THE COUNT.

SOURCE:
CWF

99. INPATIENT/SNF CLAIM PROCEDURE CODE COUNT	NUM	2	502	503	THE COUNT OF THE NUMBER OF PROCEDURE CODES (BOTH PRIN AND OTHER) REPORTED ON AN INPATIENT/SNF CLAIM. THE P OF THIS COUNT IS TO INDICATE HOW MANY CLAIM PROCEDURE TRAILERS ARE PRESENT.
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2 DIGITS UNSIGNED

DB2 ALIAS: IP_PRCDR_CD_CNT
SAS ALIAS: IPPRCNT
STANDARD ALIAS: IP_CLM_PRCDR_CD_CNT

EDIT-RULES:
RANGE: 0 TO 6

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_PRCDR_CD_CNT.

SOURCE:
CWF

100. INPATIENT/SNF CLAIM RELATED CONDITION CODE COUNT	NUM	2	504	505	THE COUNT OF THE NUMBER OF CONDITION CODES REPORTED O INPATIENT/SNF CLAIM. THE PURPOSE OF THIS COUNT IS TO INDICATE HOW MANY CONDITION CODE TRAILERS ARE PRESENT
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2 DIGITS UNSIGNED

DB2 ALIAS: IP_RLT_COND_CD_CNT
SAS ALIAS: IPCONCNT
STANDARD ALIAS: IP_CLM_RLT_COND_CD_CNT

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
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101. INPATIENT/SNF CLAIM RELATED OCCURRENCE CODE COUNT	NUM	2	506	507	THE COUNT OF THE NUMBER OF OCCURRENCE CODES REPORTED INPATIENT/SNF CLAIM. THE PURPOSE OF THIS COUNT IS TO INDICATE HOW MANY OCCURRENCE CODE TRAILERS ARE PRESEN 2 DIGITS UNSIGNED DB2 ALIAS: IP_OCRNC_CD_CNT SAS ALIAS: IPOCRCNT STANDARD ALIAS: IP_CLM_RLT_OCRNC_CD_CNT EDIT-RULES: RANGE: 0 TO 30 COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_RLT_OCRNC_CD_CNT. SOURCE: CWF
102. INPATIENT/SNF CLAIM OCCURRENCE SPAN CODE COUNT	NUM	2	508	509	THE COUNT OF THE NUMBER OF OCCURRENCE SPAN CODES REPORTED ON AN INPATIENT/SNF CLAIM. THE PURPOSE OF THE COUNT IS TO INDICATE HOW MANY SPAN CODE TRAILERS ARE PRESENT. 2 DIGITS UNSIGNED DB2 ALIAS: IP_OCRNC_SPAN_CNT SAS ALIAS: IPSPNCNT STANDARD ALIAS: IP_CLM_OCRNC_SPAN_CD_CNT COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED:

SOURCE:
CWF

103.	INPATIENT/SNF CLAIM VALUE CODE COUNT	NUM	2	510	511	THE COUNT OF THE NUMBER OF VALUE CODES REPORTED ON AN INPATIENT/SNF CLAIM. THE PURPOSE OF THE COUNT IS TO INDICATE HOW MANY VALUE CODE TRAILERS ARE PRESENT.
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2 DIGITS UNSIGNED

DB2 ALIAS: IP VAL CD CNT

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1          FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001
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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					<p>SAS ALIAS: IPVALCNT</p> <p>STANDARD ALIAS: IP_CLM_VAL_CD_CNT</p> <p>EDIT-RULES:</p> <p>RANGE: 0 TO 36</p> <p>COMMENT:</p> <p>PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_VAL_CD_CNT.</p> <p>SOURCE:</p> <p>CWF</p>
104. INPATIENT/SNF REVENUE CENTER CODE COUNT	NUM	2	512	513	<p>THE COUNT OF THE NUMBER OF REVENUE CODES REPORTED ON AN INPATIENT/SNF CLAIM. THE PURPOSE OF THE COUNT IS TO INDICATE HOW MANY REVENUE CENTER TRAILERS ARE PRESENT.</p> <p>2 DIGITS UNSIGNED</p> <p>DB2 ALIAS: IP_REV_CNTR_CD_CNT</p> <p>SAS ALIAS: IPREVCNT</p> <p>STANDARD ALIAS: IP_REV_CNTR_CD_I_CNT</p> <p>EDIT-RULES:</p> <p>RANGE: 0 TO 45</p>

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_REV_CNTR_CD_CNT.

NOTE: DURING THE VERSION 'I' CONVERSION THE
NUMBER OF OCCURRENCES CHANGED TO 45 (PER
SEGMENT - 450 TOTAL FOR CLAIM). FOR
CLAIMS PRIOR TO VERSION 'I' THE NUMBER OF
OCCURRENCES WAS 58, BUT IN THE CONVERSION
WE MADE ALL CLAIMS BACK TO SERVICE YEAR
1991 CONTAIN ONLY 45 REVENUE CENTER LINES.
IT IS POSSIBLE THAT CLAIMS PRIOR TO 1991
WILL HAVE 2 SEGMENTS IF THEY CONTAINED
MORE THAN 45 REVENUE LINES.

SOURCE:

CWF

105. FILLER CHAR 4 514 517

**** FI INPATIENT SNF CLAIM GROUP 288 518 805 DATA PERTAINING ONLY TO FISCAL INTERMEDIARY INPATIENT
SPECIFIC GROUP OR SNF CLAIMS

STANDARD ALIAS: FI_IP_SNF_CLM_SPECF_GRP

106. CLAIM ADMISSION DATE NUM 8 518 525 ON AN INSTITUTIONAL CLAIM, THE DATE THE BENEFICIARY
WAS ADMITTED TO THE HOSPITAL, SKILLED NURSING
FACILITY, OR CHRISTIAN SCIENCE SANITORIUM.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
						8 DIGITS UNSIGNED
						DB2 ALIAS: CLM_ADMSN_DT
						SAS ALIAS: ADMSN_DT
						STANDARD ALIAS: CLM_ADMSN_DT
						TITLE ALIAS: ADMISSION_DT
						EDIT-RULES:
						YYYYMMDD

Item	Code	Type	Length	Start	End	Description
107.	CLAIM INPATIENT ADMISSION TYPE CODE	CHAR	1	526	526	THE CODE INDICATING THE TYPE AND PRIORITY OF AN INPATIENT ADMISSION ASSOCIATED WITH THE SERVICE ON AN INTERMEDIARY SUBMITTED CLAIM. SOURCE: CWF DB2 ALIAS: IP_ADMSN_TYPE_CD SAS ALIAS: TYPE_ADM STANDARD ALIAS: CLM_IP_ADMSN_TYPE_CD TITLE ALIAS: IP_ADMISSION_TYPE CODES: REFER TO: CLM_IP_ADMSN_TYPE_TB IN THE CODES APPENDIX
108.	CLAIM SOURCE INPATIENT ADMISSION CODE	CHAR	1	527	527	THE CODE INDICATING THE MEANS BY WHICH THE BENEFICIARY WAS ADMITTED TO THE INPATIENT HEALTH CARE FACILITY OR SNF IF THE TYPE OF ADMISSION IS (1) EMERGENCY, (2) URGENT, OR (3) ELECTIVE. SOURCE: CWF DB2 ALIAS: SRC_IP_ADMSN_CD SAS ALIAS: SRC_ADMS STANDARD ALIAS: CLM_SRC_IP_ADMSN_CD TITLE ALIAS: IP_ADMISSION_SOURCE CODES: REFER TO: CLM_SRC_IP_ADMSN_TB IN THE CODES APPENDIX
109.	CLAIM ADMITTING DIAGNOSIS CODE	CHAR	5	528	532	AN ICD-9-CM CODE ON THE INSTITUTIONAL INPATIENT/ SNF CLAIM INDICATING THE BENEFICIARY'S INITIAL DIAGNOSIS AT ADMISSION. SOURCE: CWF DB2 ALIAS: CLM_ADMTG_DGNS_CD SAS ALIAS: AD_DGNS STANDARD ALIAS: CLM_ADMTG_DGNS_CD

TITLE ALIAS: ADMITTING_DIAGNOSIS

SOURCE:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					CWF
110. FILLER	CHAR	1	533	533	
111. NCH PATIENT STATUS INDICATOR CODE	CHAR	1	534	534	EFFECTIVE WITH VERSION H, THE CODE ON AN INPATIENT/SNF AND HOSPICE CLAIM, INDICATING WHETHER THE BENEFICIARY WAS DISCHARGED, DIED OR STILL A PATIENT (USED FOR INTERNAL CWFMQA EDITING PURPOSES.)

NOTE: DURING THE VERSION H CONVERSION THIS
FIELD WAS POPULATED THROUGHOUT HISTORY (BACK TO
SERVICE YEAR 1991).

DB2 ALIAS: NCH_PTNT_STUS_IND
SAS ALIAS: PTNTSTUS
STANDARD ALIAS: NCH_PTNT_STUS_IND_CD
TITLE ALIAS: NCH_PATIENT_STUS

DERIVATION:

DERIVED FROM:

NCH_PTNT_DSCHRG_STUS_CD

DERIVATION RULES:

SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE
PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20' - '30'
OR '40' - '42'.

SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE
PTNT_DSCHRG_STUS_CD EQUAL TO '20' - '29'
OR '40' - '42'.

SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE
PTNT_DSCHRG_STUS_CD EQUAL TO '30'

CODES:

A = DISCHARGED

B = DIED

C = STILL PATIENT

SOURCE:

NCH QA PROCESS

112. NCH INPATIENT PRO APPROVAL CHAR 1 535 535 THE PEER REVIEW ORGANIZATION (PRO) DETERMINATION ON T
TYPE CODE OF APPROVAL OR DENIAL OF AN INPATIENT CLAIM.

DB2 ALIAS: IP_PRO_APRVL_CD

SAS ALIAS: APRVL_CD

STANDARD ALIAS: NCH_IP_PRO_APRVL_TYPE_CD

TITLE ALIAS: PRO_IP_APPROVAL_CODE

DERIVATION:

SET BASED UPON PRESENCE OF CONDITION CODE

EQUAL TO C1, C3, C4, C5, C6 OR C7.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
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CODES:

REFER TO: NCH_IP_PRO_APRVL_TYPE_TB
IN THE CODES APPENDIX

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_IP_PRO_APRVL_TYPE_CD.

SOURCE:

NCH

113. NCH INPATIENT PRO APPROVAL NUM 8 536 543 ON AN INSTITUTIONAL CLAIM, THE START DATE OF
SERVICE FROM DATE SERVICE THAT HAS BEEN APPROVED BY THE PEER
REVIEW ORGANIZATION (PRO).

8 DIGITS UNSIGNED

DB2 ALIAS: IP_PRO_FROM_DT

SAS ALIAS: PRO_FROM

STANDARD ALIAS: NCH_IP_PRO_SRVC_FROM_DT
TITLE ALIAS: PRO_FROM_DT

EDIT-RULES:
YYYYMMDD

DERIVATION:
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_FROM_DT

DERIVATION RULES:
BASED ON THE PRESENCE OF OCCURRENCE SPAN CODE
EQUAL TO 'MO' MOVE THE CORRESPONDING OCCURRENCE
SPAN FROM DATE TO THE NCH_IP_PRO_SRVC_FROM_DT.

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_PRO_APRVL_SRVC_FROM_DT.

SOURCE:
NCH

114.	NCH INPATIENT PRO APPROVAL	NUM	8	544	551	ON AN INSTITUTIONAL CLAIM, THE LAST DAY OF SERVICE THRU DATE
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8 DIGITS UNSIGNED

DB2 ALIAS: IP_PRO_THRU_DT
SAS ALIAS: PRO_THRU
STANDARD ALIAS: NCH_IP_PRO_SRVC_THRU_DT
TITLE ALIAS: PRO_THRU

EDIT-RULES:
YYYYMMDD

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
-----	----	-----	-----	-----
				DERIVATION: DERIVED FROM:

CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_THRU_DT

DERIVATION RULES:
BASED ON THE PRESENCE OF OCCURRENCE SPAN CODE
EQUAL TO 'MO' MOVE THE CORRESPONDING OCCURRENCE
SPAN THRU DATE TO THE NCH_IP_PRO_SRVC_THRU_DT.

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_PRO_APRVL_SRVC_THRU_DT.

SOURCE:
NCH

115.	NCH INPATIENT PRO APPROVAL	NUM	1	552	552	ON AN INSTITUTIONAL CLAIM, THE NUMBER OF DAYS DETERMINED BY A PEER REVIEW ORGANIZATION (PRO) TO BE NECESSARY TO ARRANGE POST-DISCHARGE CARE.
	GRACE DAY COUNT					

1 DIGIT UNSIGNED

DB2 ALIAS: IP_PRO_GRC_CNT
SAS ALIAS: GRC_DAY
STANDARD ALIAS: NCH_IP_PRO_GRC_DAY_CNT
TITLE ALIAS: GRACE_DAYS

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
BASED ON THE PRESENCE OF VALUE CODE EQUAL TO '46'
MOVE THE CORRESPONDING VALUE AMOUNT TO THE
NCH_IP_PRO_GRC_DAY_CNT.

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_PRO_APRVL_GRC_DAY_CNT.

SOURCE:
NCH

116.	CLAIM PASS THRU PER DIEM	PACK	6	553	558	THE AMOUNT OF THE ESTABLISHED REIMBURSABLE COSTS
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AMOUNT

FOR THE CURRENT YEAR DIVIDED BY THE ESTIMATED
MEDICARE DAYS FOR THE CURRENT YEAR (ALL PPS
CLAIMS), AS CALCULATED BY THE FI AND REIM-
BURSEMENT STAFF. ITEMS REIMBURSED AS A PASS
THROUGH INCLUDE CAPITAL-RELATED COSTS; DIRECT
MEDICAL EDUCATION COSTS; KIDNEY ACQUISITION
COSTS FOR HOSPITALS APPROVED AS RTCS; AND
BAD DEBTS (PER PROVIDER REIMBURSEMENT MANUAL,
PART 1, SECTION 2405.2). **NOTE: PASS THROUGH
ARE NOT INCLUDED IN THE CLAIM PAYMENT AMOUNT.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					9.2 DIGITS SIGNED
					DB2 ALIAS: PASS_THRU_PER_DIEM SAS ALIAS: PER_DIEM STANDARD ALIAS: CLM_PASS_THRU_PER_DIEM_AMT TITLE ALIAS: PER_DIEM
					COMMENT: PRIOR TO VERSION H THE FIELD SIZE WAS: S9(5)V99.
					SOURCE: CWF
117. NCH BENEFICIARY INPATIENT DEDUCTIBLE AMOUNT	PACK	6	559	564	THE AMOUNT OF THE DEDUCTIBLE THE BENEFICIARY PAID FOR INPATIENT SERVICES, AS ORIGINALLY SUBMITTED ON THE INSTITUTIONAL CLAIM.
					9.2 DIGITS SIGNED
					DB2 ALIAS: BENE_IP_DDCTBL_AMT SAS ALIAS: DED_AMT STANDARD ALIAS: NCH_BENE_IP_DDCTBL_AMT TITLE ALIAS: BENE_DED_AMT
					DERIVATION: DERIVED FROM: CLM_VAL_CD

CLM_VAL_AMT

DERIVATION RULES:

BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
A1, B1, OR C1 MOVE THE CORRESPONDING VALUE
AMOUNT TO THE NCH_BENE_IP_DDCTBL_AMT.

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:
BENE_IP_DDCTBL_AMT AND THE FIELD SIZE WAS
S9(5)V99).

SOURCE:

NCH

118. NCH BENEFICIARY PART A PACK 6 565 570 THE AMOUNT OF MONEY FOR WHICH THE INTERMEDIARY HAS
COINSURANCE LIABILITY
AMOUNT DETERMINED THAT THE BENEFICIARY IS LIABLE FOR
PART A COINSURANCE ON THE INSTITUTIONAL CLAIM.

9.2 DIGITS SIGNED

DB2 ALIAS: PTA_COINSRNC_AMT

SAS ALIAS: COIN_AMT

STANDARD ALIAS: NCH_BENE_PTA_COINSRNC_AMT

TITLE ALIAS: BENE_PTA_COINSURANCE

DERIVATION:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					DERIVED FROM:
					CLM_VAL_CD
					CLM_VAL_AMT
					DERIVATION RULES:
					BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
					8, 9, 10 OR 11 MOVE THE CORRESPONDING VALUE
					AMOUNT TO THE NCH_BENE_IP_PTA_COINSRC_AMT.
					COMMENT:
					PRIOR TO VERSION H THIS FIELD WAS NAMED:
					BENE_PTA_COINSRNC_LBLTY_AMT AND THE FIELD SIZE

WAS S9(5)V99.

SOURCE:
NCH

119.	NCH BENEFICIARY BLOOD DEDUCTIBLE LIABILITY AMOUNT	PACK	6	571	576	THE AMOUNT OF MONEY FOR WHICH THE INTERMEDIARY DETERMINED THE BENEFICIARY IS LIABLE FOR THE BLOOD DEDUCTIBLE.
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9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD_DDCTBL_AMT
SAS ALIAS: BLDDDEDAM
STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT
TITLE ALIAS: BLOOD_DEDUCTIBLE

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
'06' MOVE THE CORRESPONDING VALUE AMOUNT TO
NCH_BENE_BLOOD_DDCTBL_AMT.

COMMENT:
PRIOR TO VERSION H, THIS FIELD WAS NAMED:
BENE_BLOOD_DDCTBL_LBLTY_AMT AND THE FIELD
SIZE WAS S9(5)V99. ALSO, FOR OP CLAIMS, THIS
FIELD WAS STORED IN A BLOOD TRAILER. VERSION
H ELIMINATED THE OP BLOOD TRAILER.

SOURCE:
NCH QA PROCESS

120.	NCH BLOOD TOTAL CHARGE AMOUNT	PACK	6	577	582	EFFECTIVE WITH VERSION H, THE TOTAL CHARGE FOR BLOOD USAGE (FOR INTERNAL CWFMQA EDITING PURPOSES).
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NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK
TO SERVICE YEAR 1991).

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
						9.2 DIGITS SIGNED
						DB2 ALIAS: BLOOD_TOT_CHRG_AMT SAS ALIAS: BLDTCHRG STANDARD ALIAS: NCH_BLOOD_TOT_CHRG_AMT TITLE ALIAS: BLOOD_CHARGES
						DERIVATION: DERIVED FROM: REV_CNTR_CD REV_CNTR_TOT_CHRG_AMT
						DERIVATION RULES: BASED ON THE PRESENCE OF REVENUE CENTER CODES 0380 THRU 0389 MOVE THE RELATED TOTAL CHARGE AMOUNT TO THE NCH_BLOOD_TOT_CHRG_AMT.
						SOURCE: NCH QA PROCESS
121. NCH BLOOD NON-COVERED CHARGE AMOUNT	PACK	6	583	588		EFFECTIVE WITH VERSION H, THE TOTAL NONCOVERED CHARGES FOR BLOOD USAGE (FOR INTERNAL CWFMOA EDITING PURPOSES) . NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991) . 9.2 DIGITS SIGNED
						DB2 ALIAS: BLOOD_NCVR_AMT SAS ALIAS: BLDNCHRG STANDARD ALIAS: NCH_BLOOD_NCOV_CHRG_AMT TITLE ALIAS: BLOOD_NCV_CHARGES
						DERIVATION: DERIVED FROM: REV_CNTR_CD

REV_CNTR_NCOV_CHRG_AMT

DERIVATION RULES:

BASED ON THE PRESENCE OF REVENUE CENTER CODES EQUAL TO 0380 THRU 0389 MOVE THE RELATED NONCOVERED CHARGES TO NCH_BLOOD_NCOV_CHRG_AMT.

SOURCE:

NCH QA PROCESS

122. NCH PROFESSIONAL COMPONENT PACK 6 589 594 EFFECTIVE WITH VERSION H, FOR INPATIENT AND OUT-PATIENT CLAIMS, THE AMOUNT OF PHYSICIAN AND OTHER PROFESSIONAL CHARGES COVERED UNDER MEDICARE PART B (USED FOR INTERNAL CWFMQA EDITING PURPOSES AND OTHER INTERNAL PROCESSES (E.G. IF COMPUTING INTERIM PAYMENT THESE CHARGES ARE DEDUCTED)).

CHARGE AMOUNT

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
<p>NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).</p> <p>9.2 DIGITS SIGNED</p> <p>DB2 ALIAS: PROFNL_CMPNT_AMT SAS ALIAS: PCCHGAMT STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT TITLE ALIAS: PROFNL_CMPNT_CHARGES</p> <p>DERIVATION:</p> <p>1. IF INPATIENT - DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT</p> <p>DERIVATION RULES: BASED ON THE PRESENCE OF VALUE CODE 04 OR 05 MOVE THE RELATED VALUE AMOUNT TO THE NCH_PROFNL_CMPNT_CHRG_AMT.</p>					

2. IF OUTPATIENT - DERIVED FROM:

REV_CNTR_CD
REV_CNTR_TOT_CHRG_AMT

DERIVATION RULES (EFFECTIVE 10/98):
BASED ON THE PRESENCE OF REVENUE CENTER CODES
096X, 097X & 098X MOVE THE RELATED TOTAL CHARGE
AMOUNT TO NCH_PROFNL_CMPNT_CHRG_AMT.

NOTE1: DURING THE VERSION H CONVERSION, THIS
FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY
BUT THE DERIVATION RULE APPLIED TO THE OUTPATIENT
CLAIM WAS INCOMPLETE (I.E., REVENUE CODES 0972,
0973, 0974 AND 0979 WERE OMITTED FROM THE CALCU-
LATION).

SOURCE:
NCH QA PROCESS

123. NCH INPATIENT NONCOVERED PACK 6 595 600 EFFECTIVE WITH VERSION H, THE NONCOVERED CHARGES
CHARGE AMOUNT FOR ALL ACCOMMODATIONS AND SERVICES, REPORTED ON
AN INPATIENT CLAIM (USED FOR INTERNAL CWFMQA
EDITING PURPOSES).

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK
TO SERVICE YEAR 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: IP_NCVR_CHRG_AMT
SAS ALIAS: NCCHGAMT
STANDARD ALIAS: NCH_IP_NCOV_CHRG_AMT
TITLE ALIAS: IP_NCOV_CHARGES

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
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DERIVATION:
DERIVED FROM:
REV_CNTR_CD
REV_CNTR_NCVR_CHRG_AMT

DERVIATION RULES:

BASED ON THE PRESENCE OF REVENUE CENTER CODE
EQUAL TO 0001 MOVE THE RELATED NONCOVERED CHARGE
AMOUNT TO NCH_IP_NCOV_CHRG_AMT.

SOURCE:

NCH QA PROCESS

124. NCH INPATIENT TOTAL
DEDUCTION AMOUNT

PACK

6

601

606

EFFECTIVE WITH VERSION H, THE TOTAL PART A
DEDUCTIONS REPORTED ON THE INPATIENT CLAIM (USED
FOR INTERNAL CWFMQA EDITING PURPOSES).

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK
TO 1991), BUT THE DERIVATION RULE APPLIED WAS IN-
COMPLETE FOR CLAIMS PROCESSED PRIOR TO 10/93.
DISREGARD ANY DATA PRESENT IN THIS FIELD ON CLAIMS
WITH NCH WEEKLY PROCESS DATE EARLIER THAN 10/93.

9.2 DIGITS SIGNED

DB2 ALIAS: IP_TOT_DDCTN_AMT

SAS ALIAS: TDEDAMT

STANDARD ALIAS: NCH_IP_TOT_DDCTN_AMT

TITLE ALIAS: IP_TOT_DEDUCTIONS

DERIVATION:

DERIVED FROM:

CLM_VAL_CD

CLM_VAL_AMT

DERIVATION RULES (EFFECTIVE 10/93):

ACCUMULATE THE VALUE AMOUNTS ASSOCIATED WITH
VALUE CODES EQUAL TO 06, 08 THRU 11 AND A1, B1
OR C1 AND MOVE TO IP_TOT_DDCTN_AMT.

NOTE: VALUE CODES 08-11 DID NOT EXIST IN THE
NCH PRIOR TO 2/93; VALUES CODES A1, B1, C1 DID
NOT EXIST PRIOR TO 10/93.

SOURCE:

NCH QA PROCESS

125. CLAIM TOTAL PPS CAPITAL

PACK

6

607

612

THE TOTAL AMOUNT THAT IS PAYABLE FOR CAPITAL

AMOUNT

PPS FOR THE CLAIM. THIS IS THE SUM OF THE
CAPITAL HOSPITAL SPECIFIC PORTION, FEDERAL
SPECIFIC PORTION, OUTLIER PORTION,
DISPROPORTIONATE SHARE PORTION, INDIRECT
MEDICAL EDUCATION PORTION, EXCEPTION PAYMENTS,
AND HOLD HARMLESS PAYMENTS.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					9.2 DIGITS SIGNED
					DB2 ALIAS: TOT_PPS_CPTL_AMT
					SAS ALIAS: PPS_CPTL
					STANDARD ALIAS: CLM_TOT_PPS_CPTL_AMT
					TITLE ALIAS: PPS_CAPITAL
					COMMENT:
					PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS:
					S9(7)V99.
					SOURCE:
					CWF
126. CLAIM PPS CAPITAL HSP AMOUNT	PACK	6	613	618	EFFECTIVE 3/2/92, THE HOSPITAL SPECIFIC PORTION OF THE PPS PAYMENT FOR CAPITAL.
					9.2 DIGITS SIGNED
					DB2 ALIAS: PPS_CPTL_HSP_AMT
					SAS ALIAS: CPTL_HSP
					STANDARD ALIAS: CLM_PPS_CPTL_HSP_AMT
					TITLE ALIAS: PPS_CAPITAL_HSP
					EDIT-RULES:
					\$\$\$\$\$\$\$\$\$CC
					COMMENT:
					PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS:
					S9(7)V99.
					SOURCE:

SOURCE:
CWF

129.	CLAIM PPS CAPITAL DISPROPORTIONATE SHARE AMOUNT	PACK	6	631	636	EFFECTIVE 3/2/92, THE AMOUNT OF DISPROPORTIONATE SHARE (RATE REFLECTING INDIGENT POPULATION SERVED) PORTION OF THE PPS PAYMENT FOR CAPITAL.
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9.2 DIGITS SIGNED

DB2 ALIAS: PPS_DSPRPRTNT_AMT
SAS ALIAS: DISP_SHR
STANDARD ALIAS: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT
TITLE ALIAS: PPS_DISP_SHR

EDIT-RULES:
\$\$\$\$\$\$\$\$\$CC

COMMENT:
PRIOR TO VERSION H THE SIZE OF THE FIELD WAS:
S9(7)V99.

SOURCE:
CWF

130.	CLAIM PPS CAPITAL IME AMOUNT	PACK	6	637	642	EFFECTIVE 3/2/92, THE AMOUNT OF THE INDIRECT MEDICAL EDUCATION (IME) (REIMBURSABLE AMOUNT FOR TEACHING HOSPITALS ONLY; AN ADDED AMOUNT PASSED BY CONGRESS TO AUGMENT NORMAL PPS PAYMENTS FOR TEACHING HOSPITALS TO COMPENSATE THEM FOR HIGHER PATIENT COSTS RESULTING FROM MEDICAL EDUCATION PROGRAMS FOR INTERNS AND RESIDENTS) PORTION OF THE PPS PAYMENT FOR CAPITAL.
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9.2 DIGITS SIGNED

DB2 ALIAS: PPS_CPTL_IME_AMT
SAS ALIAS: IME_AMT
STANDARD ALIAS: CLM_PPS_CPTL_IME_AMT
TITLE ALIAS: PPS_CPTL_IME

EDIT-RULES:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

POSITIONS

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					<p>\$\$\$\$\$\$\$\$\$CC</p> <p>COMMENT: PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS: S9(7)V99.</p> <p>SOURCE: CWF</p>
131. CLAIM PPS CAPITAL EXCEPTION AMOUNT	PACK	6	643	648	<p>EFFECTIVE 3/2/92, THE CAPITAL PPS AMOUNT OF EXCEPTION PAYMENTS PROVIDED FOR HOSPITALS WITH INORDINATELY HIGH LEVELS OF CAPITAL OBLIGATIONS. EXCEPTION PAYMENTS EXPIRE AT THE END OF THE 10-YEAR TRANSITION PERIOD.</p> <p>9.2 DIGITS SIGNED</p> <p>DB2 ALIAS: PPS_EXCPTN_AMT SAS ALIAS: CPTL_EXP STANDARD ALIAS: CLM_PPS_CPTL_EXCPTN_AMT TITLE ALIAS: PPS_CPTL_EXCP</p> <p>EDIT-RULES: \$\$\$\$\$\$\$\$\$CC</p> <p>COMMENT: PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS: S9(7)V99.</p> <p>SOURCE: CWF</p>
132. CLAIM PPS OLD CAPITAL HOLD HARMLESS AMOUNT	PACK	6	649	654	<p>EFFECTIVE 3/2/92, THIS AMOUNT IS THE HOLD HARMLESS AMOUNT PAYABLE FOR OLD CAPITAL AS COMPUTED BY PRICER FOR PROVIDERS WITH A PAYMENT CODE EQUAL TO 'A'. THE HOLD HARMLESS AMOUNT-OLD CAPITAL IS 100 PERCENT OF THE REASONABLE COSTS OF OLD CAPITAL FOR SOLE COMMUNITY HOSPITALS, OR 85 PERCENT OF THE REASONABLE COSTS ASSOCIATED WITH OLD CAPITAL FOR ALL OTHER HOSPITALS, PLUS A PAYMENT FOR NEW CAPITAL.</p> <p>9.2 DIGITS SIGNED</p>

DB2 ALIAS: PPS_CPTL_HRMLS_AMT
 SAS ALIAS: HLDHRMLS
 STANDARD ALIAS: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT
 TITLE ALIAS: PPS_CPTL_HOLD_HRMLS

EDIT-RULES:
 \$\$\$\$\$\$\$\$CC

COMMENT:
 PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS:
 S9(7)V99.

SOURCE:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

					CWF
133. CLAIM PPS CAPITAL DISCHARGE FRACTION PERCENT	PACK	3	655	657	EFFECTIVE 3/2/92, THE PERCENT RESULTING FROM DIVIDING THE DAYS BY THE AVERAGE LENGTH OF STAY FOR CAPITAL PPS TRANSFER CASES (PRICER REVIEW CODES 03, 05, 06) NOT TO EXCEED 1. 1.4 DIGITS SIGNED DB2 ALIAS: PPS_DSCHRG_PCT SAS ALIAS: DSCHFRCT STANDARD ALIAS: CLM_PPS_CPTL_DSCHRG_FRCTN_PCT TITLE ALIAS: PPS_CAPITL_DSCHRG_FRACTION_PCT SOURCE: CWF
134. CLAIM PPS CAPITAL DRG WEIGHT NUMBER	PACK	4	658	661	EFFECTIVE 3/2/92, THE NUMBER USED TO DETERMINE A TRANSFER ADJUSTED CASE MIX INDEX FOR CAPITAL PPS. THE NUMBER IS DETERMINED BY MULTIPLYING THE DRG WEIGHT TIMES THE DISCHARGE FRACTION. 3.4 DIGITS SIGNED DB2 ALIAS: PPS DRG WT NUM

137. BENEFICIARY TOTAL COINSURANCE DAYS COUNT	PACK	2	666	667	THE COUNT OF THE TOTAL NUMBER OF COINSURANCE DAYS INVOLVED WITH THE BENEFICIARY'S STAY IN A FACILITY. 3 DIGITS SIGNED DB2 ALIAS: COINSRNC_DAY_CNT SAS ALIAS: COIN_DAY STANDARD ALIAS: BENE_TOT_COINSRNC_DAY_CNT TITLE ALIAS: COINSRNC_DAYS SOURCE: CWF
138. CLAIM COINSURANCE YEAR 1 DAY COUNT	PACK	2	668	669	EFFECTIVE WITH VERSION H, THE COUNT OF THE NUMBER OF COINSURANCE DAYS DURING THE FIRST YEAR OF THE BILL (USED FOR INTERNAL CWFMQA EDITING PURPOSES). NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 SHOULD CONTAIN ZEROES IN THIS FIELD. EXCEPTION: DURING THE VERSION 'H' CONVERSION INVALID DATA MAY HAVE BEEN POPULATED FOR PRIOR PERIODS. DISREGARD ANY DATA IN THIS FIELD ON CLAIMS WITH NCH WEEKLY PROCESS DATE EARLIER THAN 10/3/97. 3 DIGITS SIGNED DB2 ALIAS: COINS_YR1_DAY_CNT SAS ALIAS: COYR1DAY STANDARD ALIAS: CLM_COINSRNC_YR_1_DAY_CNT TITLE ALIAS: COINS_YR1_DAYS SOURCE: CWF
139. NCH COINSURANCE YEAR 1 RATE AMOUNT	PACK	6	670	675	EFFECTIVE WITH VERSION H, THE CHARGE FOR EACH DAY OF COINSURANCE DURING THE FIRST YEAR IN THE BILL (USED FOR INTERNAL CWFMQA EDITING PURPOSES). NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 SHOULD CONTAIN ZEROES IN THIS FIELD. EXCEPTION: DURING THE

VERSION 'H' CONVERSION INVALID DATA MAY HAVE BEEN
POPULATED FOR PRIOR PERIODS. DISREGARD ANY
DATA PRESENT IN THIS FIELD ON CLAIMS WITH NCH
WEEKLY PROCESS DATE EARLIER THAN 10/3/97.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					9.2 DIGITS SIGNED
					DB2 ALIAS: COINS_YR1_RATE_AMT SAS ALIAS: COYR1AMT STANDARD ALIAS: NCH_COINSRNC_YR_1_RATE_AMT TITLE ALIAS: COINS_YR1_RATE
					DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT CLM_COINSRNC_YR_1_DAY_CNT
					DERIVATION RULES: DIVIDE THE VALUE AMOUNT ASSOCIATED WITH VALUE CODE EQUAL TO 09 BY THE COINSURANCE YEAR 1 DAYS AND MOVE TO NCH_COINSRNC_YR_1_RATE_AMT.
					SOURCE: NCH QA PROCESS
140. CLAIM COINSURANCE YEAR 2 DAY COUNT	PACK	2	676	677	EFFECTIVE WITH VERSION H, THE COUNT OF THE NUMBER OF COINSURANCE DAYS DURING THE SECOND YEAR OF THE BILL WHICH SPANS TWO YEARS (USED FOR INTERNAL CWFMQA EDITING PURPOSES.)
					NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 SHOULD CONTAIN ZEREOES IN THIS FIELD. EXCEPTION: DURING THE VERSION 'H' CONVERSION INVALID DATA MAY HAVE BEEN POPULATED FOR PRIOR PERIODS. DISREGARD ANY DATA IN THIS FIELD ON CLAIMS WITH NCH WEEKLY PROCESS DATE EARLIER THAN 10/3/97.

```
DB2 ALIAS: COINS_YR2_DAY_CNT
SAS ALIAS: COYR2DAY
STANDARD ALIAS: CLM_COINSRNC_YR_2_DAY_CNT
TITLE ALIAS: COINS_YR2_DAYS
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141.	NCH COINSURANCE YEAR 2 RATE	PACK	6	678	683	EFFECTIVE WITH VERSION H, THE CHARGE FOR EACH DAY OF COINSURANCE DURING THE SECOND YEAR IN A BILL WHICH SPANS TWO YEARS (USED FOR INTERNAL CWFMOA EDITING PURPOSES.)
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NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 SHOULD CONTAIN
ZEROS IN THIS FIELD. EXCEPTION: DURING THE
VERSION 'H' CONVERSION INVALID DATA MAY HAVE

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					BEEN POPULATED FOR PRIOR PERIODS. DISREGARD ANY DATA IN THIS FIELD ON CLAIMS WITH NCH WEEKLY PROCESS DATE EARLIER THAN 10/3/97.

```
DB2 ALIAS: COINS_YR2_RATE_AMT
SAS ALIAS: COYR2AMT
STANDARD ALIAS: NCH_COINSRNC_YR_2_RATE_AMT
TITLE ALIAS: COINS_YR2_RATE
```

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT
CLM_COINSRNC YR 2 DAY CNT

DERIVATION RULES:

SOURCE:
NCH OA PROCESS

3 DIGITS SIGNED

SOURCE:
CWF

5 DIGITS SIGNED

```
DB2 ALIAS: NUTLZTN_DAY_CNT
SAS ALIAS: NUTILDAY
STANDARD ALIAS: CLM_NUTLZTN_DAY_CNT
TITLE ALIAS: NUTLZTN_DAYS
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1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
...

SOURCE:
CWF

144. BENEFICIARY PRIOR
PSYCHIATRIC DAY COUNT

PACK

2

689

690

EFFECTIVE WITH VERSION H, THE NUMBER OF DAYS
IN A PSYCHIATRIC HOSPITAL PRIOR TO THE
ENTITLEMENT TO MEDICARE.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
ZEREOES IN THIS FIELD.

3 DIGITS SIGNED

DB2 ALIAS: PRIOR_PSYCH_CNT
SAS ALIAS: PSYCHDAY
STANDARD ALIAS: BENE_PRIOR_PSYCH_DAY_CNT
TITLE ALIAS: PRIOR_PSYCH_DAYS

SOURCE:
CWF

145. NCH BLOOD PINTS FURNISHED
QUANTITY

PACK

2

691

692

NUMBER OF WHOLE PINTS OF BLOOD FURNISHED TO THE
BENEFICIARY.

3 DIGITS SIGNED

DB2 ALIAS: NCH_BLOOD_PT_FRNSH
SAS ALIAS: BLDFRNSH
STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY
TITLE ALIAS: BLOOD_PINTS_FURNISHED

EDIT-RULES:
NUMERIC

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
BASED ON THE PRESENCE OF VALUE CODE EQUAL TO
37 MOVE THE RELATED VALUE AMOUNT TO THE
NCH_BLOOD_PT_FRNSH_QTY.

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_BLOOD_PT_FRNSH_QTY. ALSO FOR OUTPATIENT
CLAIMS THIS FIELD WAS STORED IN A BLOOD
TRAILER. VERSION H ELIMINATED THE OUTPATIENT
BLOOD TRAILER.

SOURCE:
NCH QA PROCESS

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
146.	NCH BLOOD PINTS REPLACED QUANTITY	PACK	2	693	694	NUMBER OF WHOLE PINTS OF BLOOD REPLACED. 3 DIGITS SIGNED DB2 ALIAS: BLOOD_PT_RPLC_QTY SAS ALIAS: BLD_RPLC STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY TITLE ALIAS: BLOOD_PINTS_REPLACED EDIT-RULES: NUMERIC DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT DERIVATION RULES: BASED ON THE PRESENCE OF VALUE CODE EQUAL TO 39 MOVE THE RELATED VALUE AMOUNT TO THE NCH_BLOOD_PT_RPLC_QTY. COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_BLOOD_PT_RPLC_QTY. ALSO FOR OUTPATIENT CLAIMS THIS FIELD WAS STORED IN A BLOOD TRAILER. VERSION H ELIMINATED THE OUTPATIENT BLOOD TRAILER.

SOURCE:
NCH QA PROCESS

147. NCH BLOOD PINTS NOT PACK 2 695 696 NUMBER OF WHOLE PINTS OF BLOOD NOT REPLACED.
REPLACED QUANTITY

3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_NRPLC_QTY
SAS ALIAS: BLDNRPLC
STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY
TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED

EDIT-RULES:
NUMERIC

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
SUBTRACT VALUE CODE 39 AMOUNT FROM VALUE CODE
37 AMOUNT AND MOVE THE RESULT TO
NCH_BLOOD_PT_NRPLC_QTY.

COMMENT:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_BLOOD_PT_NRPLC_QTY. ALSO FOR OUTPATIENT CLAIMS THIS FIELD WAS STORED IN A BLOOD TRAILER. VERSION H ELIMINATED THE OUTPATIENT BLOOD TRAILER.

SOURCE:
NCH QA PROCESS

148. NCH BLOOD DEDUCTIBLE PINTS PACK 2 697 698 THE QUANTITY OF BLOOD PINTS APPLIED (BLOOD

QUANTITY

DEDUCTIBLE) .

3 DIGITS SIGNED

DB2 ALIAS: BLOOD_DDCTBL_QTY

SAS ALIAS: BLDDDEDPT

STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY

TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE

EDIT-RULES:

NUMERIC

DERIVATION:

DERIVED FROM:

CLM_VAL_CD

CLM_VAL_AMT

DERIVATION RULES:

BASED ON THE PRESENCE OF VALUE CODE EQUAL TO

38 MOVE THE RELATED VALUE AMOUNT TO THE

NCH_BLOOD_DDCTBL_PT_QTY.

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:

CLM_BLOOD_DDCTBL_PT_QTY. ALSO FOR OUTPATIENT

CLAIMS THIS FIELD WAS STORED IN A BLOOD

TRAILER. VERSION H ELIMINATED THE OUTPATIENT

BLOOD TRAILER.

SOURCE:

NCH QA PROCESS

149. NCH QUALIFIED STAY FROM DATE	NUM	8	699	706	EFFECTIVE WITH VERSION H, THE BEGINNING DATE OF THE BENEFICIARY'S QUALIFYING STAY (USED FOR INTERNAL CWFMQA EDITING PURPOSES). FOR INPATIENT CLAIMS, THE DATE RELATES TO THE PPS PORTION OF THE INLIER FOR WHICH THERE IS NO UTILIZATION TO BENEFITS. FOR SNF CLAIMS, THE DATE RELATES TO A QUALIFYING STAY FROM A HOSPITAL THAT IS AT LEAST TWO DAYS IN A ROW IF THE SOURCE OF ADMISSION IS AN 'A', OR AT LEAST THREE DAYS IN A ROW IF THE SOURCE OF ADMISSION IS OTHER THAN 'A'.
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1 NOTE: DURING THE VERSION H CONVERSION THIS FIELD
FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).
					8 DIGITS UNSIGNED
					DB2 ALIAS: QLFY_STAY_FROM_DT SAS ALIAS: QLFYFROM STANDARD ALIAS: NCH_QLFY_STAY_FROM_DT TITLE ALIAS: QLFYG_STAY_FROM_DT
					EDIT-RULES: YYYYMMDD
					DERIVATION: DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_FROM_DT
					DERIVATION RULES: BASED ON THE PRESENCE OF OCCURRENCE CODE 70 MOVE THE RELATED OCCURRENCE FROM DATE TO NCH_QLFY_STAY_FROM_DT.
					SOURCE: NCH QA PROCESS
150. NCH QUALIFY STAY THROUGH DATE	NUM	8	707	714	EFFECTIVE WITH VERSION H, THE ENDING DATE OF THE BENEFICIARY'S QUALIFYING STAY (USED FOR INTERNAL CWFMQA EDITING PURPOSES.) FOR INPATIENT CLAIMS, THE DATE RELATES TO THE PPS PORTION OF THE INLIER FOR WHICH THERE IS NO UTILIZATION TO BENEFITS. FOR SNF CLAIMS, THE DATE RELATES TO A QUALIFYING STAY FROM A HOSPITAL THAT IS AT LEAST TWO DAYS IN A ROW IF THE SOURCE OF ADMISSION IS AN 'A', OR AT LEAST THREE DAYS IN A ROW IF THE SOURCE OF ADMISSION IS OTHER THAN 'A'.

NOTE: DURING THE VERSION H, CONVERSION THIS FIELD

WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).

8 DIGITS UNSIGNED

DB2 ALIAS: QLFY_STAY_THRU_DT
SAS ALIAS: QLFYTHRU
STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT
TITLE ALIAS: QLFYG_STAY_THRU_DT

EDIT-RULES:
YYYYMMDD

DERIVATION:
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_THRU_DT

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	-----	-----	-----
					DERIVATION RULES: BASED ON THE PRESENCE OF OCCURRENCE CODE 70 MOVE THE RELATED OCCURRENCE THRU DATE TO NCH_QLFY_STAY_THRU_DT.
					SOURCE: NCH QA PROCESS
151. NCH VERIFIED NONCOVERED STAY FROM DATE	NUM	8	715	722	EFFECTIVE WITH VERSION H, THE BEGINNING DATE OF THE BENEFICIARY'S NONCOVERED STAY (USED FOR INTERNAL CWFMQA EDITING PURPOSES.)
					NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).
					8 DIGITS UNSIGNED
					DB2 ALIAS: VRFY_NCOV_FROM_DT SAS ALIAS: NCOVFROM STANDARD ALIAS: NCH_VRFY_NCOV_STAY_FROM_DT

TITLE ALIAS: VERIFIED_NCOV_FROM_DT

EDIT-RULES:
YYYYMMDD

DERIVATION:
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_FROM_DT

DERIVATION RULES:
BASED ON THE PRESENCE OF OCCURRENCE CODE 74, 76,
77 OR 79 MOVE THE RELATED OCCURRENCE FROM DATE TO
NCH_VRFY_NCOV_STAY_FROM_DT.

SOURCE:
NCH QA PROCESS

152. NCH VERIFIED NONCOVERED NUM 8 723 730 EFFECTIVE WITH VERSION H, THE ENDING DATE OF
STAY THROUGH DATE THE BENEFICIARY'S NONCOVERED STAY (USED FOR
INTERNAL CWFMQA EDITING PURPOSES.)

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO
SERVICE YEAR 1991).

8 DIGITS UNSIGNED

DB2 ALIAS: VRFY_NCVR_THRU_DT
SAS ALIAS: NCOVTHRU
STANDARD ALIAS: NCH_VRFY_NCOV_STAY_THRU_DT
TITLE ALIAS: VERIFIED_NCOV_THRU_DT

EDIT-RULES:
YYYYMMDD

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

DERIVATION:
DERIVED FROM:
CLM_OCRNC_SPAN_CD

CLM_OCRNC_SPAN_THRU_DT

DERIVATION RULES:

BASED ON THE PRESENCE OF OCCURRENCE CODE 74, 76,
77 OR 79 MOVE THE RELATED OCCURRENCE THRU DATE TO
NCH_VRFY_NCOV_STAY_THRU_DT.

SOURCE:

NCH QA PROCESS

153. NCH PROVIDER GUARANTEED
PAYMENT START DATE

NUM

8

731

738

THE DATE THAT THE GUARANTEED PAYMENT TO THE
INSTITUTIONAL PROVIDER STARTED.

8 DIGITS UNSIGNED

DB2 ALIAS: GUARNT_PMT_STRT_DT

SAS ALIAS: GURPMTDT

STANDARD ALIAS: NCH_PRVDR_GUARNT_PMT_STRT_DT

TITLE ALIAS: GARNT_PMT_DT

EDIT-RULES:

YYYYMMDD

DERIVATION:

DERIVED FROM:

CLM_RLT_OCRNC_CD

CLM_RLT_OCRNC_DT

DERIVATION RULES:

BASED ON THE PRESENCE OF OCCURRENCE CODE 20
MOVE THE RELATED OCCURRENCE DATE TO
NCH_PRVDR_GUARNT_PMT_STRT_DT.

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:

CLM_PRVDR_GUARNT_PMT_STRT_DT.

SOURCE:

NCH QA PROCESS

154. NCH UTILIZATION REVIEW
NOTICE RECEIVED DATE

NUM

8

739

746

THE DATE OF RECEIPT BY THE SKILLED NURSING
FACILITY OF A UTILIZATION REVIEW COMMITTEE'S
FINDING THAT AN ADMISSION OR FURTHER STAY WAS NO
LONGER MEDICALLY NECESSARY.

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_UR_NTC_RCV_DT

SAS ALIAS: URNTCDT

STANDARD ALIAS: NCH_UR_NTC_RCV_DT

TITLE ALIAS: UR_NTC_RCV_DT

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					EDIT-RULES: YYYYMMDD
					DERIVATION: DERIVED FROM: CLM_RLT_OCRNC_CD CLM_RLT_OCRNC_DT
					DERIVATION RULES: BASED ON THE PRESENCE OF OCCURRENCE CODE 21 MOVE THE RELATED OCCURRENCE DATE TO NCH_UR_NTC_RCV_DT.
					COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: CLM_UR_NTC_RCV_DT.
					SOURCE: NCH QA PROCESS
155. NCH ACTIVE OR COVERED LEVEL CARE THRU DATE	NUM	8	747	754	THE DATE ON A CLAIM FOR WHICH THE COVERED LEVEL OF CARE ENDED IN A GENERAL HOSPITAL OR THE ACTIVE CARE ENDED IN A PSYCHIATRIC/TB HOSPITAL.
					8 DIGITS UNSIGNED
					DB2 ALIAS: ACTV_CARE_THRU_DT SAS ALIAS: CARETHRU STANDARD ALIAS: NCH_ACTV_CVR_LVL_CARE_THRU_DT TITLE ALIAS: ACTIVE_CARE_THRU_DT

EDIT-RULES:

YYYYMMDD

DERIVATION:

DERIVED FROM:

CLM_RLT_OCRNC_CD

CLM_RLT_OCRNC_DT

DERIVATION RULES:

BASED ON THE PRESENCE OF OCCURRENCE CODE 22

MOVE THE RELATED OCCURRENCE DATE TO

NCH_ACTV_CVR_LVL_CARE_THRU_DT.

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:

CLM_ACTV_CVR_LVL_CARE_THRU_DT.

SOURCE:

NCH QA PROCESS

156. NCH BENEFICIARY MEDICARE
BENEFITS EXHAUSTED DATE

NUM

8

755

762

THE LAST DATE FOR WHICH THE BENEFICIARY HAS
MEDICARE COVERAGE. THIS IS COMPLETED ONLY WHERE
WHERE BENEFITS WERE EXHAUSTED BEFORE THE DATE OF
DISCHARGE AND DURING THE BILLING PERIOD COVERED
BY THIS INSTITUTIONAL CLAIM.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

8 DIGITS UNSIGNED

DB2 ALIAS: MDCR_BNFT_EXHST_DT

SAS ALIAS: EXHST_DT

STANDARD ALIAS: NCH_MDCR_BNFT_EXHST_DT

TITLE ALIAS: BENEFIT_EXHST_DT

EDIT-RULES:

YYYYMMDD

DERIVATION:

DERIVED FROM:

CLM_RLT_OCRNC_CD

CLM_RLT_OCRNC_DT

DERIVATION RULES (EFFECTIVE 10/93):
BASED ON THE PRESENCE OF OCCURRENCE CODE A3,
B3 OR C3 MOVE THE RELATED OCCURRENCE DATE TO
NCH_MDCR_BNFT_EXHST_DT. *NOTE: PRIOR TO
10/93, THE DATE ASSOCIATED WITH OCCURRENCE
CODE 23 WAS MOVED TO THIS FIELD.

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_MDCR_BNFT_EXHST_DT.

SOURCE:
NCH QA PROCESS

157. NCH BENEFICIARY DISCHARGE DATE	NUM	8	763	770	EFFECTIVE WITH VERSION H, ON AN INPATIENT AND HHA CLAIM, THE DATE THE BENEFICIARY WAS DISCHARGED FROM THE FACILITY OR DIED (USED FOR INTERNAL CWFMQA EDITING PURPOSES.)
--	-----	---	-----	-----	--

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO
SERVICE YEAR 1991.)

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_BENE_DSCHRG_DT
SAS ALIAS: DSCHRGDT
STANDARD ALIAS: NCH_BENE_DSCHRG_DT
TITLE ALIAS: DISCHARGE_DT

EDIT-RULES:
YYYYMMDD

DERIVATION:
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

DERIVATION RULES:
BASED ON THE PRESENCE OF PATIENT DISCHARGE STATUS

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					CODE NOT EQUAL TO 30 (STILL PATIENT), MOVE THE CLAIM THRU DATE TO THE NCH_BENE_DSCHRG_DT.
					SOURCE: NCH QA PROCESS
158. CLAIM DIAGNOSIS RELATED GROUP CODE	CHAR	3	771	773	THE DIAGNOSTIC RELATED GROUP TO WHICH A HOSPITAL CLAIM BELONGS FOR PROSPECTIVE PAYMENT PURPOSES.
					COMMON ALIAS: DRG DB2 ALIAS: CLM_DRG_CD SAS ALIAS: DRG_CD STANDARD ALIAS: CLM_DRG_CD TITLE ALIAS: DRG
					EDIT-RULES: DRG DEFINITIONS MANUAL
					COMMENT: GROUPER IS THE SOFTWARE THAT DETERMINES THE DRG FROM DATA ELEMENTS REPORTED BY THE HOSPITAL. ONCE DETERMINED, THE DRG CODE IS ONE OF THE ELEMENTS USED TO DETERMINE THE PRICE UPON WHICH TO BASE THE REIMBURSEMENT TO THE HOSPITALS UNDER PROSPECTIVE PAYMENT. NONPAYMENT CLAIMS (ZERO REIMBURSEMENT) MAY NOT HAVE A DRG PRESENT.
					SOURCE: CWF
159. CLAIM DIAGNOSIS RELATED GROUP OUTLIER STAY CODE	CHAR	1	774	774	ON AN INSTITUTIONAL CLAIM, THE CODE THAT INDICATES THE BENEFICIARY STAY UNDER THE PROSPECTIVE PAYMENT SYSTEM WHICH, ALTHOUGH CLASSIFIED INTO A SPECIFIC DIAGNOSIS RELATED GROUP, HAS AN UNUSUALLY LONG LENGTH (DAY OUTLIER) OR EXCEPTIONALLY HIGH COST (COST OUTLIER).
					DB2 ALIAS: DRG_OUTLIER_CD SAS ALIAS: OUTLR_CD STANDARD ALIAS: CLM_DRG_OUTLIER_STAY_CD

TITLE ALIAS: DRG_OUTLIER_STAY_CODE

CODES:

REFER TO: DRG_OUTLIER_STAY_TB
IN THE CODES APPENDIX

SOURCE:

CWF

160. NCH DRG OUTLIER APPROVED PACK 6 775 780 ON AN INSTITUTIONAL CLAIM, THE ADDITIONAL
PAYMENT AMOUNT ORGANIZATION DUE TO AN OUTLIER SITUATION FOR
A BENEFICIARY'S STAY UNDER THE PROSPECTIVE
PAYMENT SYSTEM, WHICH HAS BEEN CLASSIFIED
INTO A SPECIFIC DIAGNOSIS RELATED GROUP.

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
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						9.2 DIGITS SIGNED
						DB2 ALIAS: DRG_OUTLIER_AMT
						SAS ALIAS: OUTLRPMT
						STANDARD ALIAS: NCH_DRG_OUTLIER_APRV_PMT_AMT
						TITLE ALIAS: DRG_OUTLIER_PMT
						DERIVATION:
						DERIVED FROM:
						CLM_VAL_CD
						CLM_VAL_AMT
						DERIVATION RULES:
						BASED ON THE PRESENCE OF VALUE CODE EQUAL
						TO 17 MOVE THE RELATED AMOUNT TO
						NCH_DRG_OUTLIER_APRV_PMT_AMT.
						COMMENT:
						PRIOR TO VERSION H THIS FIELD WAS NAMED:
						CLM_DRG_OUTLIER_APRV_PMT_AMT AND FIELD SIZE
						WAS S9(7)V99.

SOURCE:

NCH QA PROCESS

161. CLAIM KRON INDICATOR CODE CHAR 1 781 781 EFFECTIVE WITH VERSION H, ON INPATIENT CLAIMS ONLY, THE CODE INDICATING THAT THE BILL MUST FORCE A NEW SPELL EVEN IF IT IS WITHIN 60 DAYS OF A PRIOR SPELL.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN SPACES IN THIS FIELD.

DB2 ALIAS: CLM_KRON_IND_CD
SAS ALIAS: KRON_IND
STANDARD ALIAS: CLM_KRON_IND_CD
TITLE ALIAS: KRON_IND

CODES:

K = BILL MUST FORCE A NEW SPELL EVEN
IF IT IS WITHIN 60 DAYS OF A PRIOR
SPELL

BLANK = SPELL IS NOT FORCED

SOURCE:

CWF

162. FILLER CHAR 24 782 805

**** FI INPATIENT SNF CLAIM VARIABLE GROUP VARIABLE PORTION OF THE FISCAL INTERMEDIARY INPATIENT SNF CLAIM RECORD FOR VERSION H OF THE NCH.

STANDARD ALIAS: FI_IP_SNF_CLM_VAR_GRP

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
**** NCH EDIT GROUP	GROUP	5			THE NUMBER OF CLAIM EDIT TRAILERS IS DETERMINED BY THE CLAIM EDIT CODE COUNT.
OCCURS: UP TO 13 TIMES DEPENDING ON IP_NCH_EDIT_CD_CNT					

				STANDARD ALIAS: NCH_EDIT_GRP
163.	NCH EDIT TRAILER INDICATOR CODE	CHAR	1	EFFECTIVE WITH VERSION H, THE CODE INDICATING THE PRESENCE OF AN NCH EDIT TRAILER. NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991). DB2 ALIAS: EDIT_TRLR_IND_CD SAS ALIAS: EDITIND STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD CODES: E = EDIT CODE TRAILER PRESENT SOURCE: NCH QA PROCESS
164.	NCH EDIT CODE	CHAR	4	THE CODE ANNOTATED TO THE CLAIM INDICATING THE CWFMQA EDITING RESULTS SO USERS WILL BE AWARE OF DATA DEFICIENCIES. NOTE: PRIOR TO VERSION H ONLY THE HIGHEST PRIORITY CODE WAS STORED. BEGINNING 11/98 UP TO 13 EDIT CODES MAY BE PRESENT. COMMON ALIAS: QA_ERROR_CODE DB2 ALIAS: NCH_EDIT_CD SAS ALIAS: EDIT_CD STANDARD ALIAS: NCH_EDIT_CD TITLE ALIAS: QA_ERROR_CD CODES: REFER TO: NCH_EDIT_TB IN THE CODES APPENDIX SOURCE: NCH QA EDIT PROCESS
****	NCH PATCH GROUP	GROUP	11	OCCURS: UP TO 30 TIMES DEPENDING ON IP_NCH_PATCH_CD_I_CNT STANDARD ALIAS: NCH_PATCH_GRP

165. NCH PATCH TRAILER INDICATOR CHAR 1
CODE

EFFECTIVE WITH VERSION H, THE CODE INDICATING
THE PRESENCE OF AN NCH PATCH TRAILER.

1 NOTE: DURING THE VERSION H CONVERSION THIS FIELD
FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	-----	-----	-----
					WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).
					DB2 ALIAS: PATCH_TRLR_IND_CD SAS ALIAS: PATCHIND STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD
					CODES: P = PATCH CODE TRAILER PRESENT
					SOURCE: NCH
166. NCH PATCH CODE	CHAR	2			EFFECTIVE WITH VERSION H, THE CODE ANNOTATED TO THE CLAIM INDICATING A PATCH WAS APPLIED TO THE RECORD DURING AN NCH NEARLINE RECORD CONVERSION AND/OR DURING CURRENT PROCESSING.
					NOTE: PRIOR TO VERSION H THIS FIELD WAS LOCATED IN THE THIRD AND FOURTH OCCURRENCE OF THE CLM_EDIT_CD.
					DB2 ALIAS: NCH_PATCH_CD SAS ALIAS: PATCHCD STANDARD ALIAS: NCH_PATCH_CD TITLE ALIAS: NCH_PATCH
					CODES: REFER TO: NCH_PATCH_TB IN THE CODES APPENDIX
					SOURCE: NCH

167. NCH PATCH APPLIED DATE NUM 8

EFFECTIVE WITH VERSION H, THE DATE THE NCH PATCH
WAS APPLIED TO THE CLAIM.

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_PATCH_APPLY_DT
SAS ALIAS: PATCHDT
STANDARD ALIAS: NCH_PATCH_APPLY_DT
TITLE ALIAS: NCH_PATCH_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

**** MCO PERIOD GROUP GROUP 37

THE NUMBER OF MANAGED CARE ORGANIZATION (MCO)
PERIOD DATA TRAILERS PRESENT IS DETERMINED BY
THE CLAIM MCO PERIOD TRAILER COUNT. THIS FIELD
REFLECTS THE TWO MOST CURRENT MCO PERIODS IN THE
CWF BENEFICIARY HISTORY RECORD. IT MAY HAVE NO

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	----	----	-----
					CONNECTION TO THE SERVICES ON THE CLAIM.

OCCURS: UP TO 2 TIMES
 DEPENDING ON IP_MCO_PRD_CNT

STANDARD ALIAS: MCO_PRD_GRP

168. NCH MCO TRAILER INDICATOR CHAR 1
 CODE

EFFECTIVE WITH VERSION H, THE CODE INDICATING
THE PRESENCE OF A MANAGED CARE ORGANIZATION (MCO)
TRAILER.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

COBOL ALIAS: MCO_IND

DB2 ALIAS: MCO_TRLR_IND_CD
SAS ALIAS: MCOIND
STANDARD ALIAS: NCH_MCO_TRLR_IND_CD
TITLE ALIAS: MCO_INDICATOR

CODES:
M = MCO TRAILER PRESENT

SOURCE:
NCH QA PROCESS

169. MCO CONTRACT NUMBER CHAR 5

EFFECTIVE WITH VERSION H, THIS FIELD REPRESENTS
THE PLAN CONTRACT NUMBER OF THE MANAGED CARE
ORGANIZATION (MCO) .

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: MCO_CNTRCT_NUM
SAS ALIAS: MCONUM
STANDARD ALIAS: MCO_CNTRCT_NUM
TITLE ALIAS: MCO_NUM

SOURCE:
CWF

170. MCO OPTION CODE CHAR 1

EFFECTIVE WITH VERSION H, THE CODE INDICATING
MANAGED CARE ORGANIZATION (MCO) LOCK-IN
ENROLLMENT STATUS OF THE BENEFICIARY.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: MCO_OPTN_CD
SAS ALIAS: MCOOPTN

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
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STANDARD ALIAS: MCO_OPTN_CD
TITLE ALIAS: MCO_OPTION_CD

CODES:

*****FOR LOCK-IN BENEFICIARIES*****

A = HCFA TO PROCESS ALL PROVIDER BILLS

B = MCO TO PROCESS ONLY IN-PLAN

C = MCO TO PROCESS ALL PART A AND PART B BILLS

***** FOR NON-LOCK-IN BENEFICIARIES*****

1 = HCFA TO PROCESS ALL PROVIDER BILLS

2 = MCO TO PROCESS ONLY IN-PLAN PART A AND
PART B BILLS

SOURCE:

CWF

171. MCO PERIOD EFFECTIVE DATE NUM 8

EFFECTIVE WITH VERSION H, THE DATE THE BENEFICIARY'S ENROLLMENT IN THE MANAGED CARE ORGANIZATION (MCO) BECAME EFFECTIVE.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN ZEROES IN THIS FIELD.

8 DIGITS UNSIGNED

DB2 ALIAS: MCO_PRD_EFCTV_DT

SAS ALIAS: MCOEFFDT

STANDARD ALIAS: MCO_PRD_EFCTV_DT

TITLE ALIAS: MCO_PERIOD_EFF_DT

EDIT-RULES:

YYYYMMDD

SOURCE:

CWF

172. MCO PERIOD TERMINATION DATE NUM 8

EFFECTIVE WITH VERSION H, THE DATE THE BENEFICIARY'S ENROLLMENT IN THE MANAGED CARE ORGANIZATION (MCO) WAS TERMINATED.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE

10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
ZEREOES IN THIS FIELD.

8 DIGITS UNSIGNED

DB2 ALIAS: MCO_PRD_TRMNTN_DT
SAS ALIAS: MCOTRMDT
STANDARD ALIAS: MCO_PRD_TRMNTN_DT
TITLE ALIAS: MCO_PERIOD_TERM_DT

EDIT-RULES:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					YYYYMMDD
					SOURCE: CWF
173. MCO HEALTH PLANID NUMBER	CHAR	14			A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H) FOR STORING THE HEALTH PLANID ASSOCIATED WITH THE MANAGED CARE ORGANIZATION (MCO). PRIOR TO VERSION 'I' THIS FIELD WAS NAMED: MCO_PAYERID_NUM. DB2 ALIAS: MCO_PLANID_NUM SAS ALIAS: MCOPLNID STANDARD ALIAS: MCO_HLTH_PLANID_NUM TITLE ALIAS: MCO_PLANID COMMENT: PRIOR TO VERSION I THIS FIELD WAS NAMED: MCO_PAYERID_NUM. SOURCE: CWF
**** CLAIM HEALTH PLANID GROUP	GROUP	16			THE NUMBER OF HEALTH PLANID DATA TRAILERS IS DETERMIN BY THE CLAIM HEALTH PLANID TRAILER COUNT. PRIOR TO VERSION 'I' THIS FIELD WAS NAMED: CLM_PAYERID_GRP.

OCCURS: UP TO 3 TIMES
 DEPENDING ON IP_CLM_HLTH_PLANID_CNT

STANDARD ALIAS: CLM_HLTH_PLANID_GRP

174. NCH HEALTH PLANID TRAILER CHAR 1
 INDICATOR CODE

A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
 FOR STORING THE CODE THAT INDICATES THE PRESENCE
 OF A HEALTH PLANID TRAILER. NOTE: PRIOR TO
 VERSION 'I' THIS FIELD WAS NAMED:
 NCH_PAYERID_TRLR_IND_CD.

DB2 ALIAS: PLANID_TRLR_CD
 SAS ALIAS: PLANIDIN
 STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD

CODES:
 I = HEALTH PLANID TRAILER PRESENT

COMMENT:
 PRIOR TO VERSION I THIS FIELD WAS NAMED:
 NCH_PAYERID_TRLR_IND_CD.

SOURCE:
 NCH

175. CLAIM HEALTH PLANID CODE CHAR 1

A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
 FOR STORING THE CODE IDENTIFYING THE TYPE OF
 HEALTH PLANID. PRIOR TO VERSION 'I' THIS FIELD

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
-----	----	-----	-----	-----
				WAS NAMED: CLM_PAYERID-CD
				DB2 ALIAS: CLM_PLANID_CD
				SAS ALIAS: PLANIDCD
				STANDARD ALIAS: CLM_HLTH_PLANID_CD
				TITLE ALIAS: PLANID_TYPE
				CODES:
				1 = MEDICARE SECONDARY PAYER
				2 = MEDICAID

3 = MEDIGAP
4 = SUPPLEMENTAL INSURER
5 = MANAGED CARE ORGANIZATION

COMMENT:
PRIOR TO VERSION I THIS FIELD WAS NAMED:
CLM_PAYERID_CD.

SOURCE:
CWF

176. CLAIM HEALTH PLANID NUMBER CHAR 14

A PLACEHOLDER FIELD (EFFECTIVE WITH VERSION H)
FOR STORING THE HEALTH PLANID NUMBER. PRIOR
TO VERSION 'I' THIS FIELD WAS NAMED:
CLM_PAYERID_NUM.

DB2 ALIAS: CLM_PLANID_NUM
SAS ALIAS: PLANID
STANDARD ALIAS: CLM_HLTH_PLANID_NUM
TITLE ALIAS: PLANID

COMMENT:
PRIOR TO VERSION I THIS FIELD WAS NAMED:
CLM_PAYERID_NUM.

SOURCE:
CWF

**** CLAIM DEMONSTRATION IDENTIFICATION GROUP GROUP 18

THE NUMBER OF DEMONSTRATION IDENTIFICATION
TRAILERS PRESENT IS DETERMINED BY THE CLAIM
DEMONSTRATION IDENTIFICATION TRAILER COUNT.

OCCURS: UP TO 5 TIMES
DEPENDING ON IP_CLM_DEMO_ID_CNT

STANDARD ALIAS: CLM_DEMO_ID_GRP

177. NCH DEMONSTRATION TRAILER INDICATOR CODE CHAR 1

EFFECTIVE WITH VERSION H, THE CODE INDICATING
THE PRESENCE OF A DEMO TRAILER.

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
YEAR 1991).

1 COBOL ALIAS: DEMO_IND
DB2 ALIAS: DEMO_TRLR_IND_CD
FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	----	----	-----
					SAS ALIAS: DEMOIND STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD TITLE ALIAS: DEMO_INDICATOR CODES: D = DEMO TRAILER PRESENT SOURCE: NCH
178. CLAIM DEMONSTRATION IDENTIFICATION NUMBER	CHAR	2			EFFECTIVE WITH VERSION H, THE NUMBER ASSIGNED TO IDENTIFY A DEMO. THIS FIELD IS ALSO USED TO DENOTE SPECIAL PROCESSING (A.K.A. SPECIAL PROCESSING NUMBER, SPN). NOTE: PRIOR TO VERSION H, DEMO ID WAS STORED IN THE REDEFINED CLAIM EDIT GROUP, 4TH OCCURRENCE, POSITIONS 3 AND 4. DURING THE H CONVERSION, THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (AS APPRO- PRIATE EITHER BY MOVING ID ON VERSION G OR BY DERIVING FROM SPECIFIC DEMO CRITERIA). 01 = NURSING HOME CASE-MIX AND QUALITY: NHCMQ (RUGS) DEMO -- TESTING PPS FOR SNFS IN 6 STATES, USING A CASE-MIX CLASSIFICATION SYSTEM BASED ON RESIDENT CHARACTERISTICS AND ACTUAL RESOURCES USED. THE CLAIMS CARRY A RUGS INDICATOR AND ONE OR MORE REVENUE CENTER CODES IN THE 9,000 SERIES. NOTE1: EFFECTIVE FOR SNF CLAIMS WITH NCH WEEKLY PROCESS DATE AFTER 2/8/96 (AND SERVICE DATE AFTER 12/31/95) -- BEGINNING 4/97, DEMO ID '01' WAS DERIVED IN NCH BASED ON PRESENCE OF RUGS PHASE # '2','3' OR '4' ON INCOMING CLAIM; SINCE 7/97, CWF HAS BEEN ADDING ID TO CLAIM.

NOTE2: DURING THE VERSION H CONVERSION, DEMO ID '01' WAS POPULATED BACK TO NCH WEEKLY PROCESS DATE 2/9/96 BASED ON THE RUGS PHASE INDICATOR (STORED IN CLAIM EDIT GROUP, 3RD OCCURRENCE, 4TH POSITION, IN VERSION G).

02 = NATIONAL HHA PROSPECTIVE PAYMENT DEMO -- TESTING PPS FOR HHAS IN 5 STATES, USING TWO ALTERNATE METHODS OF PAYING HHAS: PER VISIT BY TYPE OF HHA VISIT AND PER EPISODE OF HH CARE.

NOTE1: EFFECTIVE FOR HHA CLAIMS WITH NCH WEEKLY PROCESS DATE AFTER 5/31/95 -- BEGINNING 4/97, DEMO ID '02' WAS DERIVED IN NCH BASED ON HCFA/CHPP-SUPPLIED LISTING OF PROVIDER # AND START/STOP DATES OF PARTICIPANTS.

NOTE2: DURING THE VERSION H CONVERSION, DEMO ID

1

FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				'02' WAS POPULATED BACK TO NCH WEEKLY PROCESS DATE 6/95 BASED ON THE CHPP CRITERIA.
				03 = TELEMEDICINE DEMO -- TESTING COVERING TRADITIONALLY NONCOVERED PHYSICIAN SERVICES FOR MEDICAL CONSULTATION FURNISHED VIA TWO-WAY, INTERACTIVE VIDEO SYSTEMS (I.E. TELECONSULTATION) IN 4 STATES. THE CLAIMS CONTAIN LINE ITEMS WITH 'QQ' HCPCS CODE.
				NOTE1: EFFECTIVE FOR PHYSICIAN/SUPPLIER (NONDMERC) CLAIMS WITH NCH WEEKLY PROCESS DATE AFTER 12/31/96 (AND SERVICE DATE AFTER 9/30/96) -- SINCE 7/97, CWF HAS BEEN ADDING DEMO ID '03' TO CLAIM.
				NOTE2: DURING VERSION H CONVERSION, DEMO ID '03' WAS POPULATED BACK TO NCH WEEKLY PROCESS DATE 1/97 BASED ON THE PRESENCE OF 'QQ' HCPCS ON ONE OR MORE LINE ITEMS.

04 = UNITED MINE WORKERS OF AMERICA (UMWA) MANAGED CARE DEMO -- TESTING RISK SHARING FOR PART A SERVICES, PAYING SPECIAL CAPITATION RATES FOR ALL UMWA BENEFICIARIES RESIDING IN 13 DESIGNATED COUNTIES IN 3 STATES. UNDER THE DEMO, UMWA WILL WAIVE THE 3-DAY QUALIFYING HOSPITAL STAY FOR A SNF ADMISSION. THE CLAIMS CONTAIN TOB '18X', '21X', '28X' AND '51X'; CONDITION CODE = W0; CLAIM MCO PAID SWITCH = NOT '0'; AND MCO CONTRACT # = '90091'.

NOTE: INITIALLY SCHEDULED TO BE IMPLEMENTED FOR ALL SNF CLAIMS FOR ADMISSION OR SERVICES ON 1/1/97 OR LATER, CWF DID NOT TRANSMIT ANY DEMO ID '04' ANNOTATED CLAIMS UNTIL ON OR ABOUT 2/98.

05 = MEDICARE CHOICES (MCO ENCOUNTER DATA) DEMO -- TESTING EXPANDING THE TYPE OF MANAGED CARE PLANS AVAILABLE AND DIFFERENT PAYMENT METHODS AT 16 MCOS IN 9 STATES. THE CLAIMS CONTAIN ONE OF THE SPECIFIC MCO PLAN CONTRACT # ASSIGNED TO THE CHOICES DEMO SITE.

NOTE1: EFFECTIVE FOR ALL CLAIM TYPES WITH NCH WEEKLY PROCESS DATE AFTER 7/31/97 -- CWF ADDS DEMO ID '05' TO CLAIM BASED ON THE PRESENCES OF THE MCO PLAN CONTRACT #.

NOTE2: DURING THE VERSION H CONVERSION, DEMO ID '05' WAS POPULATED BACK TO NCH WEEKLY PROCESS DATE 8/97 BASED ON THE PRESENCE OF THE CHOICES INDICATOR (STORED AS AN ALPHA CHARACTER CROSSED FROM MCO PLAN CONTRACT # IN THE CLAIM EDIT GROUP, 4TH OCCURRENCE, 2ND POSITION, IN VERSION 'G').

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
<hr/>					
					06 = CORONARY ARTERY BYPASS GRAFT (CABG) DEMO -- TESTING BUNDLED PAYMENT (ALL-INCLUSIVE GLOBAL PRICING) FOR HOSPITAL + PHYSICIAN SERVICES

RELATED TO CABG SURGERY IN 7 HOSPITALS IN 7 STATES. THE INPATIENT CLAIMS CONTAIN A DRG '106' OR '107'.

NOTE1: EFFECTIVE FOR INPATIENT CLAIMS AND PHYSICIAN/SUPPLIER CLAIMS WITH CLAIM EDIT DATE NO EARLIER THAN 6/1/91 (NOT ALL CABG SITES STARTED AT THE SAME TIME) -- ON 5/1/97, CWF STARTED TRANSMITTING DEMO ID '06' ON THE CLAIM. THE FI ADDS THE ID TO THE CLAIM BASED ON THE PRESENCE OF DRG '106' OR '107' FROM SPECIFIC PROVIDERS FOR SPECIFIED TIME PERIODS; THE CARRIER ADDS THE ID TO THE CLAIM BASED ON RECEIVING 'DAILY CENSUS LIST' FROM PARTICIPATING HOSPITALS. DEMO ID '06' WILL END ONCE DEMO ID '07' IS IMPLEMENTED.

NOTE2: DURING THE VERSION H CONVERSION, ANY CLAIMS WHERE MEDICARE IS THE PRIMARY PAYER THAT WERE NOT ALREADY IDENTIFIED AS DEMO ID '06' (STORED IN THE REDEFINED CLAIM EDIT GROUP, 4TH OCCURRENCE, POSITIONS 3 AND 4, VERSION G) WERE ANNOTATED BASED ON THE FOLLOWING CRITERIA: INPATIENT - PRESENCE OF DRG '106' OR '107' AND A PROVIDER NUMBER=220897, 150897, 380897, 450897, 110082, 230156 OR 360085 FOR SPECIFIED SERVICE DATES; NONINSTITUTIONAL - PRESENCE OF HCPCS MODIFIER (INITIAL AND/OR SECOND) = 'Q2' AND A CARRIER NUMBER =00700/31143 00630, 01380, 00900, 01040/00511, 00710, 00623, OR 13630 FOR SPECIFIED SERVICE DATES.

07 = PARTICIPATING CENTERS OF EXCELLENCE (PCOE) DEMO -- TESTING A NEGOTIATED ALL-INCLUSIVE PRICING ARRANGEMENT (BUNDLED RATES) FOR HIGH-COST ACUTE CARE CARDIOVASCULAR AND ORTHOPEDIC PROCEDURES PERFORMED IN 60-100 PREMIER FACILITIES IN THE CHICAGO AND SAN FRANCISCO REGIONS OR BY CURRENT CABG PROVIDERS. THE INPATIENT CLAIMS WILL CONTAIN A DRG '104', '105', '106', '107', '112', '124', '125', '209', OR '471'; THE RELATED PHYSICIAN/SUPPLIER CLAIMS WILL CONTAIN THE CLAIM PAYMENT DENIAL REASON CODE = 'D'.

NOTE: THE DEMO IS ON HOLD. THE FI AND CARRIER WILL ADD DEMO ID '07' TO CLAIM.

08 = PROVIDER PARTNERSHIP DEMO -- TESTING PER-CASE PAYMENT APPROACHES FOR ACUTE INPATIENT HOSPITALIZATIONS, MAKING A LUMP-SUM PAYMENT (COMBINING THE NORMAL PART A PPS PAYMENT WITH THE PART B ALLOWED CHARGES INTO A SINGLE FEE SCHEDULE) TO A PHYSICIAN/HOSPITAL ORGANIZATION

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					FOR ALL PART A AND PART B SERVICES ASSOCIATED WITH A HOSPITAL ADMISSION. FROM 3 TO 6 HOSPITAL IN THE NORTHEAST AND MID-ATLANTIC REGIONS MAY PARTICIPATE IN THE DEMO.

NOTE: THE DEMO IS ON HOLD. THE FI AND CARRIER WILL ADD DEMO ID '08' TO CLAIM.

15 = ESRD MANAGED CARE (MCO ENCOUNTER DATA) -- TESTING OPEN ENROLLMENT OF ESRD BENEFICIARIES AND CAPITATION RATES ADJUSTED FOR PATIENT TREATMENT NEEDS AT 3 MCOS IN 3 STATES. THE CLAIMS CONTAIN ONE OF THE SPECIFIC MCO PLAN CONTRACT # ASSIGNED TO THE ESRD DEMO SITE.

NOTE: EFFECTIVE 10/1/97 (BUT NOT ACTUALLY IMPLEMENTED AT A SITE UNTIL 1/1/98) FOR ALL CLAIM TYPES -- THE FI AND CARRIER ADD DEMO ID '15' TO CLAIM BASED ON THE PRESENCE OF THE MCO PLAN CONTRACT #.

30 = LUNG VOLUME REDUCTION SURGERY (LVRS) OR NATIONAL EMPHYSEMA TREATMENT TRIAL (NETT) CLINICAL STUDY -- EVALUATING THE EFFECTIVENESS OF LVRS AND MAXIMUM MEDICAL THERAPY (INCLUDING PULMONARY REHAB) FOR MEDICARE BENEFICIARIES IN LAST STAGES OF EMPHYSEMA AT 18 HOSPITALS NATIONALLY, IN COLLABORATION WITH NIH.

NOTE: EFFECTIVE FOR ALL CLAIM TYPES (EXCEPT DMERC) WITH NCH WEEKLY PROCESS DATE AFTER 2/27/98 (AND SERVICE DATE AFTER 10/31/97) -- THE FI ADDS DEMO ID '30' BASED ON THE PRESENCE OF A CONDITION CODE = EY; THE PARTICIPATING PHYSICIAN (NOT THE CARRIER) ADDS ID TO THE NONINSTITUTIONAL CLAIM. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (ACCESS IS RESTRICTED TO STUDY EVALUATORS ONLY).

31 = VA PRICING SPECIAL PROCESSING (SPN) -- NOT REALLY A DEMO BUT SPECIAL REQUEST FROM VA DUE TO COURT SETTLEMENT; NOT MEDICARE SERVICES BUT VA INPATIENT AND PHYSICIAN SERVICES SUBMITTED TO FI 00400 AND CARRIER 00900 TO OBTAIN MEDICARE PRICING -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (NOT IN NEARLINE FILE).

37 = MEDICARE COORDINATED CARE DEMONSTRATION -- TO TEST WHETHER COORDINATED CARE SERVICES FURNISHED TO CERTAIN BENEFICIARIES IMPROVE OUTCOMES OF CARE AND REDUCE MEDICARE EXPENDITURES UNDER PART A AND PART B. THERE WILL BE AT LEAST 9 COORDINATED

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					CARE ENTITIES (CCES). THE SELECTED ENTITIES WILL BE ASSIGNED A PROVIDER NUMBER SPECIFICALLY FOR THE DEMONSTRATION SERVICES.

NOTE: THE DEMO IS ON HOLD. THE FI AND CARRIER WILL ADD DEMO ID '37' TO CLAIM.

38 = PHYSICIAN ENCOUNTER CLAIMS - THE PURPOSE OF THIS DEMO ID IS TO IDENTIFY THE PHYSICIAN ENCOUNTER CLAIMS BEING PROCESSED AT THE HCFA DATA CENTER (THIS NUMBER WILL HELP EDS IN MAKING THE CLAIM GO THROUGH THE APPROPRIATE PROCESSING LOGIC, WHICH DIFFERS FROM THAT FOR FEE-FOR-SERVICE. **NOT

IN NCH -- AVAILABLE IN NMUD.**

NOTE: EFFECTIVE OCTOBER, 2000. DEMO IDS WILL NOT BE
ASSIGNED TO INPATIENT AND OUTPATIENT ENCOUNTER CLAIMS

39 = CENTRALIZED BILLING OF FLU AND PPV CLAIMS -- THE
PURPOSE OF THIS DEMO IS TO FACILITATE THE PROCES
CARRIER, TRAILBLAZERS, PAYING FLU AND PPV CLAIMS
BASED ON PAYMENT LOCALITIES. PROVIDERS WILL BE
GIVING THE SHOTS THROUGHOUT THE COUNTRY AND TRAN
MITTING THE CLAIMS TO TRAILBLAZERS FOR PROCESSIN

NOTE: EFFECTIVE OCTOBER, 2000 FOR CARRIER CLAIMS.

DB2 ALIAS: CLM_DEMO_ID_NUM
SAS ALIAS: DEMONUM
STANDARD ALIAS: CLM_DEMO_ID_NUM
TITLE ALIAS: DEMO_ID

SOURCE:
CWF

179. CLAIM DEMONSTRATION CHAR 15
 INFORMATION TEXT

EFFECTIVE WITH VERSION H, THE TEXT FIELD THAT
CONTAINS RELATED DEMO INFORMATION. FOR EXAMPLE,
A CLAIM INVOLVING A CHOICES DEMO ID '05' WOULD
CONTAIN THE MCO PLAN CONTRACT NUMBER IN THE FIRST
FIVE POSITIONS OF THIS TEXT FIELD.

NOTE: DURING THE VERSION H CONVERSION THIS
FIELD WAS POPULATED WITH DATA THROUGHOUT
HISTORY.

DB2 ALIAS: CLM_DEMO_INFO_TXT
SAS ALIAS: DEMOTXT
STANDARD ALIAS: CLM_DEMO_INFO_TXT
TITLE ALIAS: DEMO_INFO

DERIVATION:
DERIVATION RULES:
DEMO ID = 01 (RUGS) -- THE TEXT FIELD WILL CONTAIN
A 2, 3 OR 4 TO DENOTE THE RUGS PHASE. IF RUGS PHASE
IS BLANK OR NOT ONE OF THE ABOVE THE TEXT FIELD

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					WILL REFLECT 'INVALID'. NOTE: IN VERSION 'G', RUGS PHASE WAS STORED IN REDEFINED CLAIM EDIT GROUP, 3RD OCCURRENCE, 4TH POSITION.
					DEMO ID = 02 (HOME HEALTH DEMO) -- THE TEXT FIELD WILL CONTAIN PROV#. WHEN DEMO NUMBER NOT EQUAL TO 02 THEN TEXT WILL REFLECT 'INVALID'.
					DEMO ID = 03 (TELEMEDICINE DEMO) -- TEXT FIELD WILL CONTAIN THE HCPCS CODE. IF THE REQUIRED HCPCS IS NOT SHOWN THEN THE TEXT FIELD WILL REFLECT 'INVALID'.
					DEMO ID = 04 (UMWA) -- TEXT FIELD WILL CONTAIN W0 DENOTING THAT CONDITION CODE W0 WAS PRESENT. IF CONDITION CODE W0 NOT PRESENT THEN THE TEXT FIELD WILL REFLECT 'INVALID'.
					DEMO ID = 05 (CHOICES) -- THE TEXT FIELD WILL CONTAIN THE CHOICES PLAN NUMBER, IF BOTH OF THE FOLLOWING CONDITIONS ARE MET: (1) CHOICES PLAN NUMBER PRESENT AND PPS OR INPATIENT CLAIM SHOWS THAT 1ST 3 POSITIONS OF PROVIDER NUMBER AS '210' AND THE ADMISSION DATE IS WITHIN HMO EFFECTIVE/TERMINATION DATE; OR NON-PPS CLAIM AND THE FROM DATE IS WITHIN HMO EFFECTIVE/TERMINATION DATE AND (2) CHOICES PLAN NUMBER MATCHES THE HMO PLAN NUMBER. IF EITHER CONDITION IS NOT MET THE TEXT FIELD WILL REFLECT 'INVALID CHOICES PLAN NUMBER'. WHEN CHOICES PLAN NUMBER NOT PRESENT, TEXT WILL REFLECT 'INVALID'.
					NOTE: IN VERSION 'G', A VALID CHOICES PLAN ID IS STORED AS ALPHA CHARACTER IN REDEFINED CLAIM EDIT GROUP, 4TH OCCURRENCE, 2ND POSITION. IF INVALID, CHOICES INDICATOR 'ZZ' DISPLAYED.
					DEMO ID = 15 (ESRD MANAGED CARE) -- TEXT FIELD WILL CONTAIN THE ESRD/MCO PLAN NUMBER. IF ESRD/MCO PLAN NUMBER NOT PRESENT THE FIELD WILL

REFLECT 'INVALID'.

DEMO ID = 38 (PHYSICIAN ENCOUNTER CLAIMS) --
TEXT FIELD WILL CONTAIN THE MCO PLAN NUMBER.
WHEN MCO PLAN NUMBER NOT PRESENT THE FIELD WILL
REFLECT 'INVALID'.

SOURCE:
CWF

**** CLAIM DIAGNOSIS GROUP GROUP 7

THE NUMBER OF CLAIM DIAGNOSIS TRAILERS IS
DETERMINED BY THE CLAIM DIAGNOSIS CODE
COUNT. THE PRINCIPAL DIAGNOSIS IS THE FIRST OCCURREN
THE 'E' CODE (ICD-9-CM CODE FOR THE EXTERNAL CAUSE
OF AN INJURY, POISONING, OR ADVERSE AFFECT) IS

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

STORED AS THE LAST OCCURRENCE.
THE PRINCIPAL DIAGNOSIS AND THE 'E' CODE ARE ALSO
STORED (REDUNDANTLY) IN THE FIXED PORTION
OF THE RECORD.

NOTE:
PRIOR TO VERSION H THIS GROUP WAS NAMED:
CLM_OTHR_DGNS_GRP AND DID NOT CONTAIN THE
CLM_PRNCPAL_DGNS_CD.

OCCURS: UP TO 10 TIMES
DEPENDING ON IP_CLM_DGNS_CD_CNT

STANDARD ALIAS: CLM_DGNS_GRP

180. NCH DIAGNOSIS TRAILER CHAR 1
INDICATOR CODE

EFFECTIVE WITH VERSION H, THE CODE INDICATING
THE PRESENCE OF A DIAGNOSIS TRAILER.

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
YEAR 1991).

DB2 ALIAS: DGNS_TRLR_IND_CD

SAS ALIAS: DGNSIND
STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD

CODES:
Y = DIAGNOSIS CODE TRAILER PRESENT

SOURCE:
NCH

181. CLAIM DIAGNOSIS CODE CHAR 5

THE ICD-9-CM BASED CODE IDENTIFYING THE BENEFICIARY'S PRINCIPAL OR OTHER DIAGNOSIS (INCLUDING E CODE).

NOTE:
PRIOR TO VERSION H, THE PRINCIPAL DIAGNOSIS CODE WAS NOT STORED WITH THE 'OTHER' DIAGNOSIS CODES. DURING THE VERSION H CONVERSION THE CLM_PRNCPAL_DGNS_CD WAS ADDED AS THE FIRST OCCURRENCE.

DB2 ALIAS: CLM_DGNS_CD
SAS ALIAS: DGNS_CD
STANDARD ALIAS: CLM_DGNS_CD
TITLE ALIAS: DIAGNOSIS

EDIT-RULES:
ICD-9-CM

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
CLM_OTHR_DGNS_CD.

182. FILLER CHAR 1

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	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
	-----	----	-----	BEG	END	-----
****	CLAIM PROCEDURE GROUP	GROUP	16			THE NUMBER OF CLAIM PROCEDURE TRAILERS IS DETERMINED BY THE CLAIM PROCEDURE CODE COUNT. PRIOR TO 10/93 UP TO 10 OCCURRENCES COULD BE REPORTED ON AN INSTITUTIONAL CLAIM. BEGINNING 10/93, UP TO SIX OCCURRENCES (ONE PRINCIPAL; FIVE OTHERS) MAY BE

			REPORTED.
			OCCURS: UP TO 6 TIMES DEPENDING ON IP_CLM_PRCDR_CD_CNT
			STANDARD ALIAS: CLM_PRCDR_GRP
183. NCH PROCEDURE TRAILER INDICATOR CODE	CHAR	1	EFFECTIVE WITH VERSION H, THE CODE INDICATING THE PRE OF A PROCEDURE TRAILER.
			NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE YEAR 19
			DB2 ALIAS: PRCDR_TRLR_IND_CD SAS ALIAS: PRCDRIND STANDARD ALIAS: NCH_PRCDR_TRLR_IND_CD
			CODES: Z = PROCEDURE CODE TRAILER PRESENT
			SOURCE: NCH
184. CLAIM PROCEDURE CODE	CHAR	4	THE ICD-9-CM CODE THAT INDICATES THE PRINCIPAL OR OTH PROCEDURE PERFORMED DURING THE PERIOD COVERED BY THE INSTITUTIONAL CLAIM.
			DB2 ALIAS: CLM_PRCDR_CD SAS ALIAS: PRCDR_CD STANDARD ALIAS: CLM_PRCDR_CD TITLE ALIAS: PROCEDURE_CODE
			EDIT-RULES: ICD-9-CM
			SOURCE: CWF
185. FILLER	CHAR	3	
186. CLAIM PROCEDURE PERFORMED DATE	NUM	8	ON AN INSTITUTIONAL CLAIM, THE DATE ON WHICH THE PRINCIPAL OR OTHER PROCEDURE WAS PERFORMED.
			8 DIGITS UNSIGNED

DB2 ALIAS: CLM_PRCDR_PRFRM_DT
SAS ALIAS: PRCDR_DT
STANDARD ALIAS: CLM_PRCDR_PRFRM_DT
TITLE ALIAS: PROCEDURE_DATE

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	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
					EDIT-RULES: YYYYMMDD
					SOURCE: CWF
****	CLAIM RELATED CONDITION GROUP	GROUP	3		THE NUMBER OF CLAIM RELATED CONDITION TRAILERS IS DETERMINED BY THE CLAIM RELATED CONDITION CODE COUNT. EFFECTIVE 10/93, UP TO 30 OCCURRENCES CAN BE REPORTED ON AN INSTITUTIONAL CLAIM. PRIOR TO 10/93, UP TO 10 OCCURRENCES COULD BE REPORTED.
					OCCURS: UP TO 30 TIMES DEPENDING ON IP_CLM_RLT_COND_CD_CNT
					STANDARD ALIAS: CLM_RLT_COND_GRP
187.	NCH CONDITION TRAILER INDICATOR CODE	CHAR	1		EFFECTIVE WITH VERSION H, THE CODE INDICATING THE PRESENCE OF A CONDITION CODE TRAILER.
					NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).
					DB2 ALIAS: COND_TRLR_IND_CD SAS ALIAS: CONDIND STANDARD ALIAS: NCH_COND_TRLR_IND_CD
					CODES: C = CONDITION CODE TRAILER PRESENT
					SOURCE: NCH

188. CLAIM RELATED CONDITION CHAR 2
CODE

THE CODE THAT INDICATES A CONDITION RELATING TO
AN INSTITUTIONAL CLAIM THAT MAY AFFECT PAYER
PROCESSING.

DB2 ALIAS: CLM_RLT_COND_CD
SAS ALIAS: RLT_COND
STANDARD ALIAS: CLM_RLT_COND_CD
SYSTEM ALIAS: LTCOND
TITLE ALIAS: RELATED_CONDITION_CD

CODES:

01 THRU 16 = INSURANCE RELATED
17 THRU 30 = SPECIAL CONDITION
31 THRU 35 = STUDENT STATUS CODES WHICH ARE REQUIRED
WHEN A PATIENT IS A DEPENDENT CHILD
OVER 18 YEARS OLD
36 THRU 45 = ACCOMMODATION
46 THRU 54 = CHAMPUS INFORMATION
55 THRU 59 = SKILLED NURSING FACILITY
60 THRU 70 = PROSPECTIVE PAYMENT
71 THRU 99 = RENAL DIALYSIS SETTING
A0 THRU B9 = SPECIAL PROGRAM CODES

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					C0 THRU C9 = PRO APPROVAL SERVICES
					D0 THRU W0 = CHANGE CONDITIONS

CODES:

REFER TO: CLM_RLT_COND_TB
IN THE CODES APPENDIX

SOURCE:

CWF

**** CLAIM RELATED OCCURRENCE GROUP 11
GROUP

THE NUMBER OF CLAIM RELATED OCCURRENCE TRAILERS IS
DETERMINED BY THE CLAIM RELATED OCCURRENCE CODE COUNT
EFFECTIVE 10/93, UP TO 30 OCCURRENCES CAN BE REPORTED
ON AN INSTITUTIONAL CLAIM. PRIOR TO 10/93, UP TO 10
OCCURRENCES COULD BE REPORTED.

191.	CLAIM RELATED OCCURRENCE DATE	NUM	8	<p>CODES:</p> <p>REFER TO: CLM_RLT_OCRNC_TB IN THE CODES APPENDIX</p> <p>SOURCE:</p> <p>CWF</p> <p>THE DATE ASSOCIATED WITH A SIGNIFICANT EVENT RELATED TO AN INSTITUTIONAL CLAIM THAT MAY AFFECT PAYER PROCESSING.</p> <p>8 DIGITS UNSIGNED</p> <p>DB2 ALIAS: CLM_RLT_OCRNC_DT SAS ALIAS: OCRNCDT STANDARD ALIAS: CLM_RLT_OCRNC_DT TITLE ALIAS: RLT_OCRNC_DT</p> <p>EDIT-RULES:</p> <p>YYYYMMDD</p> <p>SOURCE:</p> <p>CWF</p>
****	CLAIM OCCURRENCE SPAN GROUP	GROUP	19	<p>THE NUMBER OF CLAIM OCCURRENCE SPAN TRAILERS IS DETERMINED BY THE CLAIM OCCURRENCE SPAN CODE COUNT. UP TO 10 OCCURRENCES MAY BE REPORTED ON AN INSTITUTIONAL CLAIM.</p> <p>OCCURS: UP TO 10 TIMES DEPENDING ON IP_CLM_OCRNC_SPAN_CD_CNT</p> <p>STANDARD ALIAS: CLM_OCRNC_SPAN_GRP</p>
192.	NCH SPAN TRAILER INDICATOR CODE	CHAR	1	<p>EFFECTIVE WITH VERSION H, THE CODE INDICATING THE PRESENCE OF A SPAN CODE TRAILER.</p> <p>NOTE: DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).</p> <p>DB2 ALIAS: SPAN_TRLR_IND_CD</p>

SAS ALIAS: SPANIND
STANDARD ALIAS: NCH_SPAN_TRLR_IND_CD

CODES:
S = SPAN CODE TRAILER PRESENT

SOURCE:
NCH

193. CLAIM OCCURRENCE SPAN CODE CHAR 2

THE CODE THAT IDENTIFIES A SIGNIFICANT EVENT
RELATING TO AN INSTITUTIONAL CLAIM THAT MAY
AFFECT PAYER PROCESSING. THESE CODES ARE
CLAIM-RELATED OCCURRENCES THAT ARE RELATED

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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					TO A TIME PERIOD (SPAN OF DATES) .

DB2 ALIAS: CLM_OCRNC_SPAN_CD
SAS ALIAS: SPAN_CD
STANDARD ALIAS: CLM_OCRNC_SPAN_CD
SYSTEM ALIAS: LTSPAN
TITLE ALIAS: SPAN_CD

CODES:
REFER TO: CLM_OCRNC_SPAN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

194. CLAIM OCCURRENCE SPAN FROM NUM 8
DATE

THE FROM DATE OF A PERIOD ASSOCIATED WITH
AN OCCURRENCE OF A SPECIFIC EVENT RELATING TO
AN INSTITUTIONAL CLAIM THAT MAY AFFECT PAYER
PROCESSING.

8 DIGITS UNSIGNED

DB2 ALIAS: OCRNC_SPAN_FROM_DT
SAS ALIAS: SPANFROM
STANDARD ALIAS: CLM_OCRNC_SPAN_FROM_DT
TITLE ALIAS: SPAN_FROM_DT

EDIT-RULES:

YYYYMMDD

SOURCE:

CWF

195. CLAIM OCCURRENCE SPAN NUM 8
THROUGH DATE

THE THRU DATE OF A PERIOD ASSOCIATED WITH AN
OCCURRENCE OF A SPECIFIC EVENT RELATING TO AN
INSTITUTIONAL CLAIM THAT MAY AFFECT PAYER
PROCESSING.

8 DIGITS UNSIGNED

DB2 ALIAS: OCRNC_SPAN_THRU_DT

SAS ALIAS: SPANTHRU

STANDARD ALIAS: CLM_OCRNC_SPAN_THRU_DT

TITLE ALIAS: SPAN_THRU_DT

EDIT-RULES:

YYYYMMDD

SOURCE:

CWF

**** CLAIM VALUE GROUP GROUP 9

THE NUMBER OF CLAIM VALUE DATA TRAILERS PRESENT IS
DETERMINED BY THE CLAIM VALUE CODE COUNT. EFFECTIVE
10/93, UP TO 36 OCCURRENCES CAN BE REPORTED ON AN
INSTITUTIONAL CLAIM. PRIOR TO 10/93, UP TO 10
OCCURRENCES COULD BE REPORTED.

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
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OCCURS: UP TO 36 TIMES
DEPENDING ON IP_CLM_VAL_CD_CNT

STANDARD ALIAS: CLM_VAL_GRP

196. NCH VALUE TRAILER INDICATOR CHAR 1
CODE

EFFECTIVE WITH VERSION H, THE CODE INDICATING
THE PRESENCE OF A VALUE CODE TRAILER.

NOTE: DURING THE VERSION H CONVERSION THIS FIELD
WAS POPULATED THROUGHOUT HISTORY (BACK TO SERVICE
YEAR 1991) .

DB2 ALIAS: VAL_TRLR_IND_CD
SAS ALIAS: VALIND
STANDARD ALIAS: NCH_VAL_TRLR_IND_CD

CODES:
V = VALUE CODE TRAILER PRESENT

SOURCE:
NCH

197. CLAIM VALUE CODE CHAR 2

THE CODE INDICATING THE VALUE OF A MONETARY
CONDITION WHICH WAS USED BY THE INTERMEDIARY
TO PROCESS AN INSTITUTIONAL CLAIM.

DB2 ALIAS: CLM_VAL_CD
SAS ALIAS: VAL_CD
STANDARD ALIAS: CLM_VAL_CD
SYSTEM ALIAS: LTVALUE
TITLE ALIAS: VALUE_CD

CODES:
REFER TO: CLM_VAL_TB
IN THE CODES APPENDIX

SOURCE:
CWF

198. CLAIM VALUE AMOUNT PACK 6

THE AMOUNT RELATED TO THE CONDITION IDENTIFIED
IN THE CLM_VAL_CD WHICH WAS USED BY THE
INTERMEDIARY TO PROCESS THE INSTITUTIONAL
CLAIM.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_VAL_AMT
SAS ALIAS: VAL_AMT
STANDARD ALIAS: CLM_VAL_AMT
TITLE ALIAS: VALUE_AMOUNT

EDIT-RULES:

\$\$\$\$\$\$\$\$\$CC

SOURCE:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
					CWF
****	CLAIM REVENUE CENTER GROUP	GROUP	224		<p>THE NUMBER OF CLAIM REVENUE CENTER DATA TRAILERS IS DETERMINED BY THE CLAIM REVENUE CENTER CODE COUNT. EFFECTIVE 7/7/00, UP TO 450 OCCURRENCES MAY BE REPORT FOR AN INSTITUTIONAL CLAIM. THE INCREASE IN THE NUMBER OF REVENUE CENTER LINES CAUSES EACH CLAIM TO BE BROKEN OUT INTO RECORDS/SEGMENTS (UP TO 10). EACH RECORD CAN HAVE UP TO 45 OCCURRENCES OF REVENUE CENTE LINES. PRIOR TO 7/7/00, UP TO 58 OCCURRENCES MAY BE REPORTED ON AN INSTITUTIONAL CLAIM. CLAIMS SUBMITTED PRIOR TO 10/93, CONTAINED UP TO 28 OCCURRENCES.</p> <p>OCCURS: UP TO 45 TIMES DEPENDING ON IP_REV_CNTR_CD_I_CNT</p> <p>STANDARD ALIAS: CLM_REV_CNTR_GRP</p> <p>COMMENT: ***** FOR SNF PPS ***** THE BALANCED BUDGET ACT MODIFIED HOW PAYMENT WILL BE MADE FOR SKILLED NURSING FACILITY (SNF) SERVICES. EFFECTIVE WITH COST REPORTING PERIODS BEGINNING ON OR AFTER 7/1/98 (WITH ALL PROVIDERS TRANSITIONING BY 6/30/99, SNFS WILL BE PAID ON A PROSPECTIVE PAYMENT SYSTEM (PPS).</p> <p>SNFS WILL CLASSIFY BENEFICIARIES ON THE BASIS OF RESIDENTS' CHARACTERISTICS AND RESOURCE NEEDS, USING THE 44-GROUP PATIENT CLASSIFICATION SYSTEM KNOWN AS RESOURCE UTILIZATION GROUPS (RUGS), VERSION III. FACILITIES WILL USE INFORMATION FROM THE MINIMUM DATA SET (MDS), VERSION 2.0, RESIDENT ASSESSMENT INSTRUMEN (RAI) TO CLASSIFY RESIDENTS INTO THE RUG-III GROUPS.</p>

***** FOR OUTPATIENT PPS *****
THE BALANCED BUDGET ACT MODIFIED HOW PAYMENT WILL BE
MADE FOR HOSPITAL OUTPATIENT SERVICES, CERTAIN PTB
SERVICES FURNISHED TO INPATIENTS WHO HAVE NO PTA
COVERAGE, CMHCS, AND LIMITED SERVICES PROVIDED BY
CORFS, HOME HEALTH AGENCIES OR TO HOSPICE PATIENTS
FOR THE TREATMENT OF A NON-TERMINAL ILLNESS. IMPE-
MENTATION FOR OUTPATIENT PPS (OPPS) WILL BE EFFECTIVE
FOR CLAIMS WITH DATES OF SERVICE ON OR AFTER
JULY 1, 2000.

PAYMENT FOR SERVICES UNDER THE OPPS SYSTEM IS
CALCULATED BASED ON GROUPING OUTPATIENT SERVICES
INTO AMBULATORY PAYMENT CLASSIFICATIONS (APC) GROUPS.

***** FOR HOME HEALTH PPS *****
THE BALANCED BUDGET ACT OF 1997 MANDATED CHANGES IN
PAYMENT AND OTHER PROVIDER REQUIREMENTS FOR HOME
HEALTH. ALL HOME HEALTH AGENCIES WILL BE PAID
THROUGH A PROSPECTIVE PAYMENT SYSTEM BEGINNING

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NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
						OCTOBER 1, 2000.
						UNDER HOME HEALTH PPS (HH PPS) THE UNIT OF PAYMENT WILL BE A 60-DAY EPISODE. HOME HEALTH RESOURCES GROUPS (HHRGS), ALSO CALLED HRGS REPRESENTED BY HCFA HIPPS CODING, WILL BE THE BASIS OF PAYMENT FOR EACH EPISODE; HHRGS WILL BE PRODUCED THROUGH PUBLICLY AVAILABLE GROUPER SOFTWARE THAT WILL DETERMINE THE APPROPRIATE HHRG WHEN RESULTS OF COMPREHENSIVE ASSESSMENTS OF THE BENEFICIARY (MADE INCORPORATING THE OASIS DATA SET) ARE INPUT OR GROUPED IN THIS SOFTWARE.
199. NCH REVENUE CENTER TRAILER INDICATOR CODE	CHAR	1				EFFECTIVE WITH VERSION H, THE CODE IDENTIFYING THE REVENUE CENTER TRAILER. DURING THE VERSION H CONVERSION THIS FIELD WAS POPULATED WITH DATA THROUGHOUT HISTORY (BACK TO SERVICE YEAR 1991).

DB2 ALIAS: REV_CNTR_TRLR_CD
 SAS ALIAS: REVIND
 STANDARD ALIAS: NCH_REV_CNTR_TRLR_IND_CD

CODES:
 R = REVENUE CODE TRAILER PRESENT

SOURCE:
 NCH

200. REVENUE CENTER CODE CHAR 4

THE PROVIDER-ASSIGNED REVENUE CODE FOR EACH COST CENT WHICH A SEPARATE CHARGE IS BILLED (TYPE OF ACCOMMODAT ANCILLARY). A COST CENTER IS A DIVISION OR UNIT WITH HOSPITAL (E.G., RADIOLOGY, EMERGENCY ROOM, PATHOLOGY) EXCEPTION: REVENUE CENTER CODE 0001 REPRESENTS THE T ALL REVENUE CENTERS INCLUDED ON THE CLAIM.

COBOL ALIAS: REV_CD
 DB2 ALIAS: REV_CNTR_CD
 SAS ALIAS: REV_CNTR
 STANDARD ALIAS: REV_CNTR_CD
 SYSTEM ALIAS: LTRC
 TITLE ALIAS: REVENUE_CENTER_CD

CODES:
 REFER TO: REV_CNTR_TB
 IN THE CODES APPENDIX

SOURCE:
 CWF

201. REVENUE CENTER DATE NUM 8

EFFECTIVE WITH VERSION H, THE DATE APPLICABLE TO THE SERVICE REPRESENTED BY THE REVENUE CENTER CODE. THIS FIELD MAY BE PRESENT ON ANY OF THE INSTITUTIONAL CLAIM TYPES. FOR HOME HEALTH CLAIMS THE SERVICE DATE SHOULD BE PRESENT ON ALL BILLS

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

WITH FROM DATE GREATER THAN 3/31/98. WITH THE IMPLEMENTATION OF OUTPATIENT PPS, HOSPITALS WILL					

BE REQUIRED TO ENTER LINE ITEM DATES OF SERVICE
FOR ALL OUTPATIENT SERVICES WHICH REQUIRE A HCPCS.

NOTE1: BEGINNING WITH NCH WEEKLY PROCESS DATE
10/3/97 THIS FIELD WAS POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 10/3/97 WILL CONTAIN
ZEROES IN THIS FIELD.

NOTE2: WHEN REVENUE CENTER CODE EQUALS '0022'
(SNF PPS) AND REVENUE CENTER HCPCS CODE NOT EQUAL
TO 'AAA00' (DEFAULT FOR NO ASSESSMENT), DATE RE-
PRESENTS THE MDS RAI ASSESSMENT REFERENCE DATE.

NOTE3: WHEN REVENUE CENTER CODE EQUALS '0023'
(HHPPS), THE DATE ON THE INITIAL CLAIM (RAP) MUST
REPRESENT THE FIRST DATE OF SERVICE IN THE EPISODE.
THE FINAL CLAIM WILL MATCH THE '0023' INFORMATION
SUBMITTED ON THE INITIAL CLAIM. THE SCIC
(SIGNIFICANT CHANGE IN CONDITION) CLAIMS MAY SHOW
ADDITIONAL '0023' REVENUE LINES IN WHICH THE
DATE REPRESENTS THE DATE OF THE FIRST SERVICE
UNDER THE REVISED PLAN OF TREATMENT.

8 DIGITS UNSIGNED

DB2 ALIAS: REV_CNTR_DT
SAS ALIAS: REV_DT
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

202. REVENUE CENTER 1ST ANSI CHAR 5
CODE

THE FIRST CODE USED TO IDENTIFY THE
DETAILED REASON AN ADJUSTMENT WAS MADE
(E.G. REASON FOR DENIAL OR REDUCING PAYMENT).

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: REV_CNTR_ANSI1_CD
SAS ALIAS: REVANSI1
STANDARD ALIAS: REV_CNTR_ANSI_1_CD
SYSTEM ALIAS: LTANSI
TITLE ALIAS: ANSI_CD

CODES:

REFER TO: REV_CNTR_ANSI_TB
IN THE CODES APPENDIX

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

					SOURCE: CWF
203. REVENUE CENTER 2ND ANSI CODE	CHAR	5			THE SECOND CODE USED TO IDENTIFY THE DETAILED REASON AN ADJUSTMENT WAS MADE (E.G. REASON FOR DENIAL OR REDUCING PAYMENT) . NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 7/7/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN SPACES IN THIS FIELD. DB2 ALIAS: REV_CNTR_ANSI2_CD SAS ALIAS: REVANSI2 STANDARD ALIAS: REV_CNTR_ANSI_2_CD TITLE ALIAS: ANSI_CD SOURCE: CWF
204. REVENUE CENTER 3RD ANSI CODE	CHAR	5			THE THIRD CODE USED TO IDENTIFY THE DETAILED REASON AN ADJUSTMENT WAS MADE (E.G. REASON FOR DENIAL OR REDUCING PAYMENT) . NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 7/7/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN SPACES IN THIS FIELD.

DB2 ALIAS: REV_CNTR_ANSI3_CD
SAS ALIAS: REVANSI3
STANDARD ALIAS: REV_CNTR_ANSI_3_CD
TITLE ALIAS: ANSI_CD

SOURCE:
CWF

205. REVENUE CENTER 4TH ANSI CHAR 5
CODE

THE FOURTH CODE USED TO IDENTIFY THE
DETAILED REASON AN ADJUSTMENT WAS MADE
(E.G. REASON FOR DENIAL OR REDUCING PAYMENT) .

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: REV_CNTR_ANSI4_CD
SAS ALIAS: REVANSI4
STANDARD ALIAS: REV_CNTR_ANSI_4_CD
TITLE ALIAS: ANSI_CD

SOURCE:
CWF

206. REVENUE CENTER APC/HIPPS CHAR 5 EFFECTIVE WITH OUTPATIENT PPS (OPPS), THE AMBULATORY
1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
CODE					PAYMENT CLASSIFICATION (APC) CODE USED TO IDENTIFY GROUPINGS OF OUTPATIENT SERVICES. APC CODES ARE USED TO CALCULATE PAYMENT FOR SERVICES UNDER OPPS. EFFECTIVE WITH HOME HEALTH PPS (HHPPS), THIS FIELD WILL ONLY BE POPULATED WITH A HIPPS CODE IF THE HIPPS CODE THAT IS STORED IN THE HCPCS FIELD HAS BEEN DOWNCODED AND THE NEW CODE WILL BE PLACED IN THIS FIELD.

NOTE1: UNDER SNF PPS AND HHPPS, HIPPS CODES ARE

STORED IN THE HCPCS FIELD. **EXCEPTION: IF A
HHPPS HIPPS CODE IS DOWNCODED THE DOWNCODED
HIPPS WILL BE STORED IN THIS FIELD.

NOTE2: BEGINNING WITH NCH WEEKLY PROCESS DATE
8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
SPACES IN THIS FIELD.

DB2 ALIAS: REV_APC_HIPPS_CD
SAS ALIAS: APCHIPPS
STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
SYSTEM ALIAS: LTAPC
TITLE ALIAS: APC_HIPPS

CODES:

REFER TO: REV_CNTR_APC_TB
IN THE CODES APPENDIX

SOURCE:

CWF

207. REVENUE CENTER HCFA COMMON CHAR 5
PROCEDURE CODING SYSTEM
CODE

HCFA'S COMMON PROCEDURE CODING SYSTEM (HCPCS)
IS A COLLECTION OF CODES THAT REPRESENT PROCEDURES,
SUPPLIES, PRODUCTS AND SERVICES WHICH MAY BE
PROVIDED TO MEDICARE BENEFICIARIES AND TO
INDIVIDUALS ENROLLED IN PRIVATE HEALTH
INSURANCE PROGRAMS. THE CODES ARE DIVIDED
INTO THREE LEVELS, OR GROUPS, AS DESCRIBED
BELOW:

DB2 ALIAS: REV_CNTR_HCPCS_CD
SAS ALIAS: HCPCS_CD
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD

CODES:

REFER TO: CLM_HIPPS_TB
IN THE CODES APPENDIX

COMMENT:

PRIOR TO VERSION H THIS FIELD WAS NAMED:
HCPCS_CD. WITH VERSION H, A PREFIX

1

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

					WAS ADDED TO DENOTE THE LOCATION OF THIS FIELD ON EACH CLAIM TYPE (INSTITUTIONAL: REV_CNTR AND NON-INSTITUTIONAL: LINE).
					NOTE: WHEN REVENUE CENTER CODE = '0022' (SNF PPS) OR '0023' (HH PPS), THIS FIELD CONTAINS THE HEALTH INSURANCE PPS (HIPPS) CODE. THE HIPPS CODE FOR SNF PPS CONTAINS THE RATE CODE/ASSESSMENT TYPE THAT IDENTIFIES (1) RUG-III GROUP THE BENEFICIARY WAS CLASSIFIED INTO AS OF THE RAI MDS ASSESSMENT REFERENC DATE AND (2) THE TYPE OF ASSESSMENT FOR PAYMENT PUR- POSES.
					THE HIPPS CODE FOR HOME HEALTH PPS IDENTIFIES (1) THE THREE CASE-MIX DIMENSIONS OF THE HHRG SYSTEM, CLINICAL, FUNCTIONAL AND UTILIZATION, FROM WHICH A BENEFICIARY IS ASSIGNED TO ONE OF THE 80 HHRG CATEGORIES AND (2) IT IDENTIFIES WHETHER OR NOT THE ELEMENTS OF THE CODE WERE COMPUTED OR DERIVED. THE HHRGS, REPRESENTED BY THE HIPPS CODING, WILL BE THE BASIS OF PAYMENT FOR EACH EPISODE.
					FOR BOTH SNF PPS & HH PPS HIPPS VALUES SEE CLM_HIPPS_
					LEVEL I CODES AND DESCRIPTORS COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY, FOURTH EDITION (CPT-4). THESE ARE 5 POSITION NUMERIC CODES REPRESENTING PHYSICIAN AND NONPHYSICIAN SERVICES.
					**** NOTE: **** CPT-4 CODES INCLUDING BOTH LONG AND SHORT DESCRIPTIONS SHALL BE USED IN ACCORDANCE WITH THE HCFA/AMA AGREEMENT. ANY OTHER USE VIOLATES THE AMA COPYRIGHT.
					LEVEL II INCLUDES CODES AND DESCRIPTORS COPYRIGHTED BY

THE AMERICAN DENTAL ASSOCIATION'S CURRENT DENTAL TERMINOLOGY, SECOND EDITION (CDT-2). THESE ARE 5 POSITION ALPHA-NUMERIC CODES COMPRISING THE D SERIES. ALL OTHER LEVEL II CODES AND DESCRIPTORS ARE APPROVED AND MAINTAINED JOINTLY BY THE ALPHA-NUMERIC EDITORIAL PANEL (CONSISTING OF HCFA, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AND THE BLUE CROSS AND BLUE SHIELD ASSOCIATION). THESE ARE 5 POSITION ALPHA-NUMERIC CODES REPRESENTING PRIMARILY ITEMS AND NONPHYSICIAN SERVICES THAT ARE NOT REPRESENTED IN THE LEVEL I CODES.

LEVEL III

CODES AND DESCRIPTORS DEVELOPED BY MEDICARE CARRIERS FOR USE AT THE LOCAL (CARRIER) LEVEL. THESE ARE 5 POSITION ALPHA-NUMERIC CODES IN THE

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
208. REVENUE CENTER HCPCS INITIAL MODIFIER CODE	CHAR	2			<p>W, X, Y OR Z SERIES REPRESENTING PHYSICIAN AND NONPHYSICIAN SERVICES THAT ARE NOT REPRESENTED IN THE LEVEL I OR LEVEL II CODES.</p> <p>A FIRST MODIFIER TO THE PROCEDURE CODE TO ENABLE A MORE SPECIFIC PROCEDURE IDENTIFICATION FOR THE CLAIM.</p> <p>DB2 ALIAS: REV_HCPCS_MDFR_CD SAS ALIAS: MDFR_CD1 STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD TITLE ALIAS: INITIAL_MODIFIER</p> <p>EDIT-RULES: CARRIER INFORMATION FILE</p> <p>COMMENT: PRIOR TO VERSION H THIS FIELD WAS NAMED: HCPCS_INITL_MDFR_CD. WITH VERSION H, A PREFIX WAS ADDED TO DENOTE THE LOCATION OF THIS FIELD ON EACH CLAIM TYPE (INSTITUTIONAL: REV_CNTR AND NON-INSTITUTIONAL: LINE).</p>

209. REVENUE CENTER HCPCS SECOND CHAR 2
MODIFIER CODE

SOURCE:
CWF

A SECOND MODIFIER TO THE PROCEDURE CODE TO MAKE IT MORE SPECIFIC THAN THE FIRST MODIFIER CODE TO IDENTIFY THE PROCEDURES PERFORMED ON THE BENEFICIARY FOR THE CLAIM

DB2 ALIAS: REV_HCPCS_2ND_CD
SAS ALIAS: MDFR_CD2
STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD
TITLE ALIAS: SECOND_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
PRIOR TO VERSION H THIS FIELD WAS NAMED:
HCPCS_2ND_MDFR_CD. WITH VERSION H, A PREFIX
WAS ADDED TO DENOTE THE LOCATION OF THIS FIELD
ON EACH CLAIM TYPE (INSTITUTIONAL: REV_CNTR AND
NON-INSTITUTIONAL: LINE).

SOURCE:
CWF

210. REVENUE CENTER HCPCS THIRD CHAR 2
MODIFIER CODE

EFFECTIVE WITH VERSION I, A THIRD MODIFIER TO THE PROCEDURE CODE TO MAKE IT MORE SPECIFIC THAN THE SECOND MODIFIER CODE TO IDENTIFY THE PROCEDURES PERFORMED ON THE BENEFICIARY FOR THE CLAIM.

DB2 ALIAS: REV_HCPCS_3RD_CD
SAS ALIAS: MDFR_CD3
STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS: THIRD_MODIFIER

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	-----	-----	-----

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 8/18/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN SPACES IN THIS FIELD.

SOURCE:
CWF

211. REVENUE CENTER HCPCS FOURTH CHAR 2
MODIFIER CODE

EFFECTIVE WITH VERSION I, A FOURTH MODIFIER TO THE PROCEDURE CODE TO MAKE IT MORE SPECIFIC THAN THE THIRD MODIFIER CODE TO IDENTIFY THE PROCEDURES PERFORMED ON THE BENEFICIARY FOR THE CLAIM.

DB2 ALIAS: REV_HCPCS_4TH_CD
SAS ALIAS: MDFR_CD4
STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE ALIAS: FOURTH_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 8/18/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN SPACES IN THIS FIELD.

SOURCE:
CWF

212. REVENUE CENTER HCPCS FIFTH CHAR 2
MODIFIER CODE

EFFECTIVE WITH VERSION I, A FIFTH MODIFIER TO THE PROCEDURE CODE TO MAKE IT MORE SPECIFIC THAN THE FOURTH MODIFIER CODE TO IDENTIFY THE PROCEDURES PERFORMED ON THE BENEFICIARY FOR THE CLAIM.

DB2 ALIAS: REV_HCPCS_5TH_CD
SAS ALIAS: MDFR_CD5
STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD
TITLE ALIAS: FIFTH_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
8/18/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN
SPACES IN THIS FIELD.

SOURCE:
CWF

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
213. REVENUE CENTER PAYMENT METHOD INDICATOR CODE	CHAR	2			<p>EFFECTIVE WITH VERSION 'I', THE CODE USED TO IDENTIFY HOW THE SERVICE IS PRICED FOR PAYMENT. THIS FIELD IS MADE UP OF TWO PIECES OF DATA, 1ST POSITION BEING THE SERVICE INDICATOR AND THE 2ND POSITION BEING THE PAYMENT INDICATOR.</p> <p>NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 8/18/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN SPACES IN THIS FIELD.</p> <p>DB2 ALIAS: REV_PMT_MTHD_CD SAS ALIAS: PMTMTHD STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD SYSTEM ALIAS: LTPMTHD TITLE ALIAS: PMT_MTHD</p> <p>CODES: REFER TO: REV_CNTR_PMT_MTHD_IND_TB IN THE CODES APPENDIX</p> <p>SOURCE: CWF</p>
214. REVENUE CENTER DISCOUNT INDICATOR CODE	CHAR	1			<p>EFFECTIVE WITH VERSION 'I', FOR ALL SERVICES SUBJECT TO OUTPATIENT PPS, THIS CODE REPRESENTS A FACTOR THAT SPECIFIES THE AMOUNT OF ANY APC DISCOUNT. THE DISCOUNTING FACTOR IS APPLIED TO A LINE ITEM WITH A SERVICE INDICATOR (PART OF THE REV_CNTR_PMT_MTHD_IND_CD) OF 'T'. THE FLAG IS APPLICABLE WHEN MORE THAN ONE SIGNIFICANT</p>

PROCEDURE IS PERFORMED. **IF THERE IS NO DISCOUNTING THE FACTOR WILL BE 1.0.**

NOTE1: BEGINNING WITH NCH WEEKLY PROCESS DATE 8/18/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN SPACES IN THIS FIELD.

DB2 ALIAS: REV_DSCNT_IND_CD
SAS ALIAS: DSCNTIND
STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
SYSTEM ALIAS: LTDSCNT
TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

CODES:
DISCOUNTING FORMULAS
1 = 1.0
2 = $(1.0 + D(U-1)) / U$
3 = T / U
4 = $(1 + D) / U$
5 = D
6 = TD / U
7 = $D(1 + D) / U$
8 = $2.0 / U$

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
215. REVENUE CENTER PACKAGING INDICATOR CODE	CHAR	1			<p>SOURCE: CWF</p> <p>EFFECTIVE WITH VERSION 'I', FOR ALL SERVICES SUBJECT TO OUTPATIENT PPS, THE CODE USED TO IDENTIFY THOSE SERVICES THAT ARE PACKAGED/ BUNDLED WITH ANOTHER SERVICE.</p>

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 8/18/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN SPACES IN THIS FIELD.

DB2 ALIAS: REV_PACKG_IND_CD

9/3/2002

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					CEIVED FROM THE PRIMARY (OR SECONDARY) PAYER.
					NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 7/7/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN SPACES IN THIS FIELD.
					DB2 ALIAS: REV_OTAF1_IND_CD SAS ALIAS: OTAF_1 STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD
					EDIT-RULES: Y = PROVIDER IS OBLIGATED TO ACCEPT THE PAYMENT AS PAYMENT IN FULL FOR THE SERVICE. N OR BLANK = PROVIDER IS NOT OBLIGATED TO ACCEPT THE PAYMENT, OR THERE IS NO PAYMENT BY A PRIOR PAYER.
					SOURCE: CWF
218. REVENUE CENTER OBLIGATION TO ACCEPT AS FULL (OTAF) PAYMENT CODE	CHAR	1			*****FIELD NOT POPULATED***** THIS FIELD WAS INTENDED TO COLLECT INFORMATION FOR TWO PAYERS IF MEDICARE WAS TERTIARY. IT WAS DISCOVERED THAT MSP SYSTEM ONLY DEALS WITH ONE PAYER SO THERE IS NO NEED TO HAVE 2 OTAF FIELDS. DB2 ALIAS: REV_OTAF2_IND_CD SAS ALIAS: OTAF_2 STANDARD ALIAS: REV_CNTR_OTAF_2_IND_CD TITLE ALIAS: REV_CNTR_OTAF_2_IND_CD SOURCE: CWF
219. REVENUE CENTER IDE, NDC, UPC NUMBER	CHAR	24			EFFECTIVE WITH VERSION H, THE EXEMPTION NUMBER ASSIGNED BY THE FOOD AND DRUG ADMINISTRATION (FDA) TO AN INVESTIGATIONAL DEVICE AFTER A MANUFACTURER HAS BEEN APPROVED BY FDA TO CONDUCT A CLINICAL TRIAL ON THAT DEVICE. HCFA ESTABLISHED A NEW

POLICY OF COVERING CERTAIN IDE'S WHICH WAS IMPLEMENTED IN CLAIMS PROCESSING ON 10/1/96 (WHICH IS NCH WEEKLY PROCESS 10/4/96) FOR SERVICE DATES BEGINNING 10/1/95. IDE'S ARE ALWAYS ASSOCIATED WITH REVENUE CENTER CODE '0624'.

NOTE1: PRIOR TO VERSION H A 'DUMMY' REVENUE CENTER CODE '0624' TRAILER WAS CREATED TO STORE IDE'S. THE IDE NUMBER WAS HOUSED IN TWO FIELDS: HCPCS CODE AND HCPCS INITIAL MODIFIER; THE SECOND MODIFIER CONTAINED THE VALUE 'ID'. THERE CAN BE UP TO 7 DISTINCT IDE NUMBERS ASSOCIATED WITH AN '0624' DUMMY TRAILER. DURING THE VERSION H CONVERSION IDE'S WERE MOVED FROM THE DUMMY '0624'

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	-----	-----	-----
					TRAILER TO THIS DEDICATED FIELD.

NOTE2: EFFECTIVE WITH VERSION 'I', THIS FIELD WAS RENAMED TO EVENTUALLY ACCOMMODATE THE NATIONAL DRUG C (NDC) AND THE UNIVERSAL PRODUCT CODE (UPC). THIS FIE COULD CONTAIN EITHER OF THESE 3 FIELDS (THERE WOULD N BE AN INSTANCE WHERE MORE THAN ONE WOULD COME IN ON A CLAIM). THE SIZE OF THIS FIELD WAS EXPANDED TO X(2 TO ACCOMMODATE EITHER OF THE NEW FIELDS (UNDER VERSIO 'H' IT WAS X(7). DATA ANAMOLY/LIMITATION: DURING AN CWFMQA REVIEW AN EDIT REVEALED THE IDE WAS MISSING. THE PROBLEM OCCURS IN CLAIM WITH AN NCH WEEKLY PROCESS DATES OF 6/9/00 THROUGH 9/8/00. DURING PROCESSI OF THE NEW FORMAT THE PROGRAM RECEIVES THE IDE BUT THEN BLANKED OUT THE DATA.

DB2 ALIAS: IDE_NDC_UPC_NUM
SAS ALIAS: IDENDC
STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
TITLE ALIAS: IDE_NDC_UPC

SOURCE:
CWF

220. REVENUE CENTER UNIT COUNT PACK 4 A QUANTITATIVE MEASURE (UNIT) OF THE NUMBER OF TIMES

SERVICE OR PROCEDURE BEING REPORTED WAS PERFORMED ACC TO THE REVENUE CENTER/HCPSC CODE DEFINITION AS DESCRIBED IN AN INSTITUTIONAL CLAIM.

DEPENDING ON TYPE OF SERVICE, UNITS ARE MEASURED BY NUMBER OF COVERED DAYS IN A PARTICULAR ACCOMMODATION, PINTS OF BLOOD, EMERGENCY ROOM VISITS, CLINIC VISITS, DIALYSIS TREATMENTS (SESSIONS OR DAYS), OUTPATIENT THERAPY VISITS AND OUTPATIENT CLINICAL DIAGNOSTIC LABORATORY TESTS.

NOTE1: WHEN REVENUE CENTER CODE = '0022' (SNF PPS) THE COUNT WILL REFLECT THE NUMBER OF COVERED DAYS FOR EACH CODE AND, IF APPLICABLE, THE NUMBER OF VISITS FOR EACH THERAPY CODE.

7 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_UNIT_CNT
SAS ALIAS: REV_UNIT
STANDARD ALIAS: REV_CNTR_UNIT_CNT
TITLE ALIAS: UNITS

SOURCE:
CWF

221. REVENUE CENTER RATE AMOUNT PACK 6

CHARGES RELATING TO UNIT COST ASSOCIATED WITH THE REVENUE CENTER CODE. EXCEPTION (ENCOUNTER DATA ONLY): IF PLAN (E.G. MCO) DOES NOT KNOW THE ACTUAL RATE FOR THE ACCOMMODATIONS, \$1 WILL BE REPORTED IN THE FIELD.

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NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
-----	----	-----	-----	-----
				NOTE1: FOR SNF PPS CLAIMS (WHEN REVENUE CENTER CODE EQUALS '0022'), HCFA HAS DEVELOPED A SNF PRICER TO COMPUTE THE RATE BASED ON THE PROVIDER SUPPLIED CODING FOR THE MDS RUGS III GROUP AND ASSESSMENT TYPE (HIPPS CODE, STORED IN REVENUE CENTER HCPSC CODE FIELD).

NOTE2: FOR OP PPS CLAIMS, HCFA HAS DEVELOPED A

PRICER TO COMPUTE THE RATE BASED ON THE AMBULATORY PAYMENT CLASSIFICATION (APC), DISCOUNT FACTOR, UNITS OF SERVICE AND THE WAGE INDEX.

NOTE3: UNDER HH PPS (WHEN REVENUE CENTER CODE EQUALS '0023'), HCFA HAS DEVELOPED A HHA PRICER TO COMPUTE THE RATE. ON THE RAP, THE RATE IS DETERMINED USING THE CASE MIX WEIGHT ASSOCIATED WITH THE HIPPS CODE, ADJUSTING IT FOR THE WAGE INDEX FOR THE BENEFICIARY'S SITE OF SERVICE, THEN MULTIPLYING THE RESULT BY 60% OR 50%, DEPENDING ON WHETHER OR NOT THE RAP IS FOR A FIRST EPISODE.

ON THE FINAL CLAIM, THE HIPPS CODE COULD CHANGE THE PAYMENT IF THE THERAPY THRESHOLD IS NOT MET, OR PARTIAL EPISODE PAYMENT (PEP) ADJUSTMENT OR A SIGNIFICANT CHANGE IN CONDITION (SCIC) ADJUSTMENT. IN CASES OF SCICS, THERE WILL BE MORE THAN ONE '0023' REVENUE CENTER LINE, EACH REPRESENTING THE PAYMENT MADE AT EACH CASE-MIX LEVEL.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_RATE_AMT
SAS ALIAS: REV_RATE
STANDARD ALIAS: REV_CNTR_RATE_AMT
TITLE ALIAS: CHARGE_PER_UNIT

EFFECTIVE-DATE: 10/01/1993

COMMENT:
PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS:
S9(7)V99.

SOURCE:
CWF

222. REVENUE CENTER BLOOD PACK 6
 DEDUCTIBLE AMOUNT

EFFECTIVE WITH VERSION 'I', THE AMOUNT OF MONEY FOR WHICH THE INTERMEDIARY DETERMINED THE BENEFICIARY IS LIABLE FOR THE BLOOD DEDUCTIBLE FOR THE LINE ITEM SERVICE.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.

CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
SPACES IN THIS FIELD.

9.2 DIGITS SIGNED

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					DB2 ALIAS: REV_BLOOD_DDCTBL SAS ALIAS: REVBLOOD STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT TITLE ALIAS: BLOOD_DDCTBL_AMT SOURCE: CWF
223. REVENUE CENTER CASH DEDUCTIBLE AMOUNT	PACK	6			EFFECTIVE WITH VERSION 'I' THE AMOUNT OF CASH DEDUCTIBLE THE BENEFICIARY PAID FOR THE LINE ITEM SERVICE. NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 7/7/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN SPACES IN THIS FIELD. 9.2 DIGITS SIGNED DB2 ALIAS: REV_CASH_DDCTBL SAS ALIAS: REVDCTBL STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT TITLE ALIAS: CASH_DDCTBL SOURCE: CWF
224. REVENUE CENTER COINSURANCE/WAGE ADJUSTED COINSURANCE AMOUNT	PACK	6			EFFECTIVE WITH VERSION 'I', THE AMOUNT OF COINSURANCE APPLICABLE TO THE LINE ITEM SERVICE DEFINED BY THE REVENUE CENTER AND HCPCS CODES. FOR THOSE SERVICES SUBJECT TO OUTPATIENT PPS, THE APPLICABLE COINSURANCE IS WAGE ADJUSTED.

NOTE1: THIS FIELD WILL HAVE EITHER A ZERO (FOR SERVICES FOR WHICH COINSURANCE IS NOT APPLICABLE), A REGULAR COINSURANCE AMOUNT (CALCULATED ON EITHER CHARGES OR A FEE SCHEDULE) OR IF SUBJECT TO OP PPS THE NATIONAL COINSURANCE AMOUNT WILL BE WAGE ADJUSTED. THE WAGE ADJUSTED COINSURANCE IS BASED ON THE MSA WHERE THE PROVIDER IS LOCATED OR ASSIGNED AS A RESULT OF A RECLASSIFICATION.

NOTE2: BEGINNING WITH NCH WEEKLY PROCESS DATE 8/18/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN SPACES IN THIS FIELD.

9.2 DIGITS SIGNED

DB2 ALIAS: ADJSTD_COINSRNC
SAS ALIAS: WAGEADJ
STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT
TITLE ALIAS: WAGE_ADJSTD_COINS

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME		POSITIONS		CONTENTS
TYPE	LENGTH	BEG	END	
-----	-----	-----	-----	-----
SOURCE:				
CWF				
225. REVENUE CENTER REDUCED COINSURANCE AMOUNT	PACK	6		EFFECTIVE WITH VERSION 'I', FOR ALL SERVICES SUBJECT TO OUTPATIENT PPS, THE AMOUNT OF COINSURANCE APPLICABLE TO THE LINE FOR A PARTICULAR SERVICE (HCPCS) FOR WHICH THE PROVIDER HAS ELECTED TO REDUCE THE COINSURANCE AMOUNT. NOTE1: THE REDUCED COINSURANCE AMOUNT CANNOT BE LOWER THAN 20% OF THE PAYMENT RATE FOR THE APC LINE. NOTE2: BEGINNING WITH NCH WEEKLY PROCESS DATE 8/18/00, THIS FIELD WILL BE POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 8/18/00 WILL CONTAIN

SPACES IN THIS FIELD.

9.2 DIGITS SIGNED

DB2 ALIAS: RDCD_COINSRNC
SAS ALIAS: RDCDCOIN
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS: REDUCED_COINS

SOURCE:
CWF

226. REVENUE CENTER 1ST MEDICARE PACK 6
SECONDARY PAYER PAID
AMOUNT

EFFECTIVE WITH VERSION 'I', THE AMOUNT PAID BY
THE PRIMARY PAYER WHEN THE PAYER IS PRIMARY TO
MEDICARE (MEDICARE IS SECONDARY OR TERTIARY).

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
SPACES IN THIS FIELD.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP1_PD_AMT
SAS ALIAS: REV_MSP1
STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

SOURCE:
CWF

227. REVENUE CENTER 2ND MEDICARE PACK 6
SECONDARY PAYER PAID
AMOUNT

EFFECTIVE WITH VERSION 'I', THE AMOUNT PAID BY
THE SECONDARY PAYER WHEN TWO PAYERS ARE PRIMARY
TO MEDICARE (MEDICARE IS THE TERTIARY PAYER).

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

		POSITIONS		
NAME	TYPE	LENGTH	BEG	END
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SPACES IN THIS FIELD.

228. REVENUE CENTER PROFESSIONAL PACK 6
 COMPONENT AMOUNT

9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP2_PD_AMT
SAS ALIAS: REV_MSP2
STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

SOURCE:
CWF

*****FIELD NOT POPULATED*****
INTENDED TO BE POPULATED FOR LINE ITEM SERVICES
SUBJECT TO PPS, AS THE AMOUNT ASSOCIATED WITH
VALUE CODE '05'. HOWEVER, WITH LINE ITEM DATE
OF SERVICE REPORTING, THERE IS NO WAY TO
CORRECTLY ALLOCATE PROFESSIONAL COMPONENT CHARGES
REPORTED IN VALUE CODE '05' TO SPECIFIC LINE ITEMS
ON THE CLAIM.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_PROFNL_CMPNT
SAS ALIAS: REVPCCHG
STANDARD ALIAS: REV_CNTR_PROFNL_CMPNT_AMT
TITLE ALIAS: PROFNL_CMPNT_CHARGES

SOURCE:
CWF

229. REVENUE CENTER PROVIDER PACK 6
 PAYMENT AMOUNT

EFFECTIVE WITH VERSION 'I', THE AMOUNT PAID
TO THE PROVIDER FOR THE SERVICES REPORTED
ON THE LINE ITEM.

NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE
7/7/00, THIS FIELD WILL BE POPULATED WITH DATA.
CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN
SPACES IN THIS FIELD.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_PRVDR_PMT_AMT
SAS ALIAS: RPRVDPMT
STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					<p>CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN SPACES IN THIS FIELD.</p> <p>9.2 DIGITS SIGNED</p> <p>DB2 ALIAS: REV_BENE_PMT_AMT SAS ALIAS: RBENEPMT STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT TITLE ALIAS: REV_BENE_PMT</p> <p>SOURCE: CWF</p>
REVENUE CENTER PATIENT RESPONSIBILITY PAYMENT AMOUNT	PACK	6			<p>EFFECTIVE WITH VERSION I, THE AMOUNT PAID BY THE BENEFICIARY TO THE PROVIDER FOR THE LINE ITEM SERVICE.</p> <p>NOTE: BEGINNING WITH NCH WEEKLY PROCESS DATE 7/7/00 THIS FIELD WAS POPULATED WITH DATA. CLAIMS PROCESSED PRIOR TO 7/7/00 WILL CONTAIN ZEROES IN THIS FIELD.</p> <p>9.2 DIGITS SIGNED</p> <p>DB2 ALIAS: REV_PTNT_RESP_AMT SAS ALIAS: PTNTRESP STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT TITLE ALIAS: REV_PTNT_RESP</p>

SOURCE:
CWF

232. REVENUE CENTER PAYMENT PACK 6
 AMOUNT

EFFECTIVE WITH VERSION 'I', THE LINE ITEM
MEDICARE PAYMENT AMOUNT FOR THE SPECIFIC
REVENUE CENTER.

UNDER OP PPS, PRICER WILL COMPUTE THE
STANDARD OPPS PAYMENT FOR A LINE ITEM BASED
ON THE PAYMENT APC.

UNDER HH PPS, PRICER WILL COMPUTE/RETURN
A LINE ITEM PAYMENT AMOUNT FOR THE CASE-MIXED,
WAGE-INDEX ADJUSTED HIPPS CODE ASSIGNED TO
THE '0023' REVENUE CENTER LINE. THE HIPPS
CODE WILL BE STORED IN THE REVENUE CENTER
HCPCS CODE FIELD.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: REV_CNTR_PMT_AMT
SAS ALIAS: REVPMT
STANDARD ALIAS: REV_CNTR_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:

1 FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	----	-----	-----	-----	-----
					\$\$\$\$\$\$\$\$\$CC

SOURCE:
CWF

233. REVENUE CENTER TOTAL CHARGE PACK 6
 AMOUNT

THE TOTAL CHARGES (COVERED AND NON-COVERED) FOR ALL
ACCOMMODATIONS AND SERVICES (RELATED TO THE REVENUE C
FOR A BILLING PERIOD BEFORE REDUCTION FOR THE DEDUCTI
COINSURANCE AMOUNTS AND BEFORE AN ADJUSTMENT FOR THE
SERVICES PROVIDED. NOTE: FOR ACCOMMODATION REVENUE C
TOTAL CHARGES MUST EQUAL THE RATE TIMES UNITS (DAYS).

EXCEPTIONS:

(1) FOR SNF RUGS DEMO CLAIMS ONLY (9000 SERIES REVENUE CENTER CODES), THIS FIELD CONTAINS SNF CUSTOMARY ACCOMMODATION CHARGE, (IE., CHARGES RELATED TO THE ACCOMMODATION REVENUE CENTER CODE THAT WOULD HAVE BEEN APPLICABLE IF THE PROVIDER HAD NOT BEEN PARTICIPATING DEMO).

(2) FOR SNF PPS (NON DEMO CLAIMS), WHEN REVENUE CENTER = '0022', THE TOTAL CHARGES WILL BE ZERO.

(3) FOR HOME HEALTH PPS (RAPS), WHEN REVENUE CENTER '0023', THE TOTAL CHARGES WILL EQUAL THE DOLLAR AMOUNT THE '0023' LINE.

(4) FOR HOME HEALTH PPS (FINAL CLAIM), WHEN REVENUE CENTER CODE = '0023', THE TOTAL CHARGES WILL BE THE SUM OF THE REVENUE CENTER CODE LINES (OTHER THAN '0023').

(5) FOR ENCOUNTER DATA, IF THE PLAN (E.G. MCO) DOES NOT KNOW THE ACTUAL CHARGES FOR THE ACCOMMODATIONS, THE TOTAL CHARGES WILL BE \$1 (RATE) TIMES UNITS (DAYS).

9.2 DIGITS SIGNED

DB2 ALIAS: REV_TOT_CHRG_AMT

SAS ALIAS: REV_CHRG

STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT

TITLE ALIAS: REVENUE_CENTER_CHARGES

EDIT-RULES:

\$\$\$\$\$\$\$\$\$CC

COMMENT:

PRIOR TO VERSION H THE SIZE OF THIS FIELD WAS:
S9(7)V99.

SOURCE:

CWF

234. REVENUE CENTER NON-COVERED PACK 6
CHARGE AMOUNT

THE CHARGE AMOUNT RELATED TO A REVENUE CENTER CODE FOR SERVICES THAT ARE NOT COVERED BY MEDICARE.

1

NOTE: PRIOR TO VERSION H THE FIELD SIZE WAS S9(7)V99
FI INPATIENT SNF CLAIM RECORD -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
						THE ELEMENT WAS ONLY PRESENT ON THE INPATIENT/SNF FOR AS OF NCH WEEKLY PROCESS DATE 10/3/97 THIS FIELD WAS . TO ALL INSTITUTIONAL CLAIM TYPES.
						9.2 DIGITS SIGNED
						DB2 ALIAS: REV_NCVR_CHRG_AMT SAS ALIAS: REV_NCVR STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES
						EDIT-RULES: \$\$\$\$\$\$\$\$\$CC
						SOURCE: CWF
235. REVENUE CENTER DEDUCTIBLE COINSURANCE CODE	CHAR	1				CODE INDICATING WHETHER THE REVENUE CENTER CHARGES ARE SUBJECT TO DEDUCTIBLE AND/OR COINSURANCE.
						DB2 ALIAS: DDCTBL_COINSRNC_CD SAS ALIAS: REVDEDCD STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD
						CODES: REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB IN THE CODES APPENDIX
						SOURCE: CWF
236. FILLER	CHAR	50				
237. END OF RECORD CODE	CHAR	3				EFFECTIVE WITH VERSION 'I', THE CODE USED TO IDENTIFY THE END OF A RECORD/SEGMENT OR THE END OF THE CLAIM.

DB2 ALIAS: END_REC_CD
 SAS ALIAS: EOR
 STANDARD ALIAS: END_REC_CD
 TITLE ALIAS: END_OF_REC

CODES:
 EOR = END OF RECORD/SEGMENT
 EOC= END OF CLAIM

COMMENT:
 PRIOR TO VERSION I THIS FIELD WAS NAMED:
 END_REC_CNSTNT.

SOURCE:
 NCH

1	BENE_IDENT_TB -----	BENEFICIARY IDENTIFICATION CODE (BIC) TABLE -----
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SOCIAL SECURITY ADMINISTRATION:

A = PRIMARY CLAIMANT
 B = AGED WIFE, AGE 62 OR OVER (1ST CLAIMANT)
 B1 = AGED HUSBAND, AGE 62 OR OVER (1ST CLAIMANT)
 B2 = YOUNG WIFE, WITH A CHILD IN HER CARE (1ST CLAIMANT)
 B3 = AGED WIFE (2ND CLAIMANT)
 B4 = AGED HUSBAND (2ND CLAIMANT)
 B5 = YOUNG WIFE (2ND CLAIMANT)
 B6 = DIVORCED WIFE, AGE 62 OR OVER (1ST CLAIMANT)
 B7 = YOUNG WIFE (3RD CLAIMANT)
 B8 = AGED WIFE (3RD CLAIMANT)
 B9 = DIVORCED WIFE (2ND CLAIMANT)
 BA = AGED WIFE (4TH CLAIMANT)
 BD = AGED WIFE (5TH CLAIMANT)
 BG = AGED HUSBAND (3RD CLAIMANT)
 BH = AGED HUSBAND (4TH CLAIMANT)
 BJ = AGED HUSBAND (5TH CLAIMANT)
 BK = YOUNG WIFE (4TH CLAIMANT)
 BL = YOUNG WIFE (5TH CLAIMANT)

BN = DIVORCED WIFE (3RD CLAIMANT)
BP = DIVORCED WIFE (4TH CLAIMANT)
BQ = DIVORCED WIFE (5TH CLAIMANT)
BR = DIVORCED HUSBAND (1ST CLAIMANT)
BT = DIVORCED HUSBAND (2ND CLAIMANT)
BW = YOUNG HUSBAND (2ND CLAIMANT)
BY = YOUNG HUSBAND (1ST CLAIMANT)
C1-C9,CA-CZ = CHILD (INCLUDES MINOR, STUDENT
OR DISABLED CHILD)
D = AGED WIDOW, 60 OR OVER (1ST CLAIMANT)
D1 = AGED WIDOWER, AGE 60 OR OVER (1ST
CLAIMANT)
D2 = AGED WIDOW (2ND CLAIMANT)
D3 = AGED WIDOWER (2ND CLAIMANT)
D4 = WIDOW (REMARRIED AFTER ATTAINMENT OF
AGE 60) (1ST CLAIMANT)
D5 = WIDOWER (REMARRIED AFTER ATTAINMENT OF
AGE 60) (1ST CLAIMANT)
D6 = SURVIVING DIVORCED WIFE, AGE 60 OR OVER
(1ST CLAIMANT)
D7 = SURVIVING DIVORCED WIFE (2ND CLAIMANT)
D8 = AGED WIDOW (3RD CLAIMANT)
D9 = REMARRIED WIDOW (2ND CLAIMANT)
DA = REMARRIED WIDOW (3RD CLAIMANT)
DD = AGED WIDOW (4TH CLAIMANT)
DG = AGED WIDOW (5TH CLAIMANT)
DH = AGED WIDOWER (3RD CLAIMANT)
DJ = AGED WIDOWER (4TH CLAIMANT)
DK = AGED WIDOWER (5TH CLAIMANT)
DL = REMARRIED WIDOW (4TH CLAIMANT)
DM = SURVIVING DIVORCED HUSBAND (2ND
CLAIMANT)
DN = REMARRIED WIDOW (5TH CLAIMANT)

1 BENE_IDENT_TB BENEFICIARY IDENTIFICATION CODE (BIC) TABLE

DP = REMARRIED WIDOWER (2ND CLAIMANT)
DQ = REMARRIED WIDOWER (3RD CLAIMANT)
DR = REMARRIED WIDOWER (4TH CLAIMANT)
DS = SURVIVING DIVORCED HUSBAND (3RD
CLAIMANT)
DT = REMARRIED WIDOWER (5TH CLAIMANT)
DV = SURVIVING DIVORCED WIFE (3RD CLAIMANT)
DW = SURVIVING DIVORCED WIFE (4TH CLAIMANT)

DX = SURVIVING DIVORCED HUSBAND (4TH CLAIMANT)
DY = SURVIVING DIVORCED WIFE (5TH CLAIMANT)
DZ = SURVIVING DIVORCED HUSBAND (5TH CLAIMANT)
E = MOTHER (WIDOW) (1ST CLAIMANT)
E1 = SURVIVING DIVORCED MOTHER (1ST CLAIMANT)
E2 = MOTHER (WIDOW) (2ND CLAIMANT)
E3 = SURVIVING DIVORCED MOTHER (2ND CLAIMANT)
E4 = FATHER (WIDOWER) (1ST CLAIMANT)
E5 = SURVIVING DIVORCED FATHER (WIDOWER) (1ST CLAIMANT)
E6 = FATHER (WIDOWER) (2ND CLAIMANT)
E7 = MOTHER (WIDOW) (3RD CLAIMANT)
E8 = MOTHER (WIDOW) (4TH CLAIMANT)
E9 = SURVIVING DIVORCED FATHER (WIDOWER) (2ND CLAIMANT)
EA = MOTHER (WIDOW) (5TH CLAIMANT)
EB = SURVIVING DIVORCED MOTHER (3RD CLAIMANT)
EC = SURVIVING DIVORCED MOTHER (4TH CLAIMANT)
ED = SURVIVING DIVORCED MOTHER (5TH CLAIMANT)
EF = FATHER (WIDOWER) (3RD CLAIMANT)
EG = FATHER (WIDOWER) (4TH CLAIMANT)
EH = FATHER (WIDOWER) (5TH CLAIMANT)
EJ = SURVIVING DIVORCED FATHER (3RD CLAIMANT)
EK = SURVIVING DIVORCED FATHER (4TH CLAIMANT)
EM = SURVIVING DIVORCED FATHER (5TH CLAIMANT)
F1 = FATHER
F2 = MOTHER
F3 = STEPFATHER
F4 = STEPMOTHER
F5 = ADOPTING FATHER
F6 = ADOPTING MOTHER
F7 = SECOND ALLEGED FATHER
F8 = SECOND ALLEGED MOTHER
J1 = PRIMARY PROUTY ENTITLED TO HIB

1

BENE_IDENT_TB

(LESS THAN 3 Q.C.) (GENERAL FUND)
J2 = PRIMARY PROUTY ENTITLED TO HIB
(OVER 2 Q.C.) (RSI TRUST FUND)
J3 = PRIMARY PROUTY NOT ENTITLED TO HIB
(LESS THAN 3 Q.C.) (GENERAL FUND)
J4 = PRIMARY PROUTY NOT ENTITLED TO HIB
BENEFICIARY IDENTIFICATION CODE (BIC) TABLE

(OVER 2 Q.C.) (RSI TRUST FUND)
K1 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
3 Q.C.) (GENERAL FUND) (1ST CLAIMANT)
K2 = PROUTY WIFE ENTITLED TO HIB (OVER 2
Q.C.) (RSI TRUST FUND) (1ST CLAIMANT)
K3 = PROUTY WIFE NOT ENTITLED TO HIB (LESS
THAN 3 Q.C.) (GENERAL FUND) (1ST
CLAIMANT)
K4 = PROUTY WIFE NOT ENTITLED TO HIB (OVER
2 Q.C.) (RSI TRUST FUND) (1ST
CLAIMANT)
K5 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
3 Q.C.) (GENERAL FUND) (2ND CLAIMANT)
K6 = PROUTY WIFE ENTITLED TO HIB (OVER 2
Q.C.) (RSI TRUST FUND) (2ND CLAIMANT)
K7 = PROUTY WIFE NOT ENTITLED TO HIB (LESS
THAN 3 Q.C.) (GENERAL FUND) (2ND
CLAIMANT)
K8 = PROUTY WIFE NOT ENTITLED TO HIB (OVER
2 Q.C.) (RSI TRUST FUND) (2ND
CLAIMANT)
K9 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
3 Q.C.) (GENERAL FUND) (3RD CLAIMANT)
KA = PROUTY WIFE ENTITLED TO HIB (OVER 2
Q.C.) (RSI TRUST FUND) (3RD CLAIMANT)
KB = PROUTY WIFE NOT ENTITLED TO HIB (LESS
THAN 3 Q.C.) (GENERAL FUND) (3RD
CLAIMANT)
KC = PROUTY WIFE NOT ENTITLED TO HIB (OVER
2 Q.C.) (RSI TRUST FUND) (3RD
CLAIMANT)
KD = PROUTY WIFE ENTITLED TO HIB (LESS THAN
3 Q.C.) (GENERAL FUND) (4TH CLAIMANT)
KE = PROUTY WIFE ENTITLED TO HIB (OVER 2 Q.C
(4TH CLAIMANT)

KF = PROUTY WIFE NOT ENTITLED TO HIB (LESS
 THAN 3 Q.C.) (4TH CLAIMANT)
 KG = PROUTY WIFE NOT ENTITLED TO HIB (OVER
 2 Q.C.) (4TH CLAIMANT)
 KH = PROUTY WIFE ENTITLED TO HIB (LESS THAN
 3 Q.C.) (5TH CLAIMANT)
 KJ = PROUTY WIFE ENTITLED TO HIB (OVER 2
 Q.C.) (5TH CLAIMANT)
 KL = PROUTY WIFE NOT ENTITLED TO HIB (LESS
 THAN 3 Q.C.) (5TH CLAIMANT)
 KM = PROUTY WIFE NOT ENTITLED TO HIB (OVER
 2 Q.C.) (5TH CLAIMANT)
 M = UNINSURED-NOT QUALIFIED FOR DEEMED HIB
 M1 = UNINSURED-QUALIFIED BUT REFUSED HIB
 T = UNINSURED-ENTITLED TO HIB UNDER DEEMED
 OR RENAL PROVISIONS
 TA = MQGE (PRIMARY CLAIMANT)
 TB = MQGE AGED SPOUSE (FIRST CLAIMANT)
 TC = MQGE DISABLED ADULT CHILD (FIRST CLAIMANT)
 TD = MQGE AGED WIDOW(ER) (FIRST CLAIMANT)
 TE = MQGE YOUNG WIDOW(ER) (FIRST CLAIMANT)
 TF = MQGE PARENT (MALE)
 TG = MQGE AGED SPOUSE (SECOND CLAIMANT)
 BENEFICIARY IDENTIFICATION CODE (BIC) TABLE

1 BENE_IDENT_TB

TH = MQGE AGED SPOUSE (THIRD CLAIMANT)
 TJ = MQGE AGED SPOUSE (FOURTH CLAIMANT)
 TK = MQGE AGED SPOUSE (FIFTH CLAIMANT)
 TL = MQGE AGED WIDOW(ER) (SECOND CLAIMANT)
 TM = MQGE AGED WIDOW(ER) (THIRD CLAIMANT)
 TN = MQGE AGED WIDOW(ER) (FOURTH CLAIMANT)
 TP = MQGE AGED WIDOW(ER) (FIFTH CLAIMANT)
 TQ = MQGE PARENT (FEMALE)
 TR = MQGE YOUNG WIDOW(ER) (SECOND CLAIMANT)
 TS = MQGE YOUNG WIDOW(ER) (THIRD CLAIMANT)
 TT = MQGE YOUNG WIDOW(ER) (FOURTH CLAIMANT)
 TU = MQGE YOUNG WIDOW(ER) (FIFTH CLAIMANT)
 TV = MQGE DISABLED WIDOW(ER) FIFTH CLAIMANT
 TW = MQGE DISABLED WIDOW(ER) FIRST CLAIMANT
 TX = MQGE DISABLED WIDOW(ER) SECOND CLAIMANT
 TY = MQGE DISABLED WIDOW(ER) THIRD CLAIMANT
 TZ = MQGE DISABLED WIDOW(ER) FOURTH CLAIMANT
 T2-T9 = DISABLED CHILD (SECOND TO NINTH)

CLAIMANT)
W = DISABLED WIDOW, AGE 50 OR OVER (1ST
CLAIMANT)
W1 = DISABLED WIDOWER, AGE 50 OR OVER (1ST
CLAIMANT)
W2 = DISABLED WIDOW (2ND CLAIMANT)
W3 = DISABLED WIDOWER (2ND CLAIMANT)
W4 = DISABLED WIDOW (3RD CLAIMANT)
W5 = DISABLED WIDOWER (3RD CLAIMANT)
W6 = DISABLED SURVIVING DIVORCED WIFE (1ST
CLAIMANT)
W7 = DISABLED SURVIVING DIVORCED WIFE (2ND
CLAIMANT)
W8 = DISABLED SURVIVING DIVORCED WIFE (3RD
CLAIMANT)
W9 = DISABLED WIDOW (4TH CLAIMANT)
WB = DISABLED WIDOWER (4TH CLAIMANT)
WC = DISABLED SURVIVING DIVORCED WIFE (4TH
CLAIMANT)
WF = DISABLED WIDOW (5TH CLAIMANT)
WG = DISABLED WIDOWER (5TH CLAIMANT)
WJ = DISABLED SURVIVING DIVORCED WIFE (5TH
CLAIMANT)
WR = DISABLED SURVIVING DIVORCED HUSBAND
(1ST CLAIMANT)
WT = DISABLED SURVIVING DIVORCED HUSBAND
(2ND CLAIMANT)

RAILROAD RETIREMENT BOARD:

NOTE:

EMPLOYEE: A MEDICARE BENEFICIARY WHO IS
STILL WORKING OR A WORKER WHO
DIED BEFORE RETIREMENT

ANNUITANT: A PERSON WHO RETIRED UNDER THE
RAILROAD RETIREMENT ACT ON OR
AFTER 03/01/37

PENSIONER: A PERSON WHO RETIRED PRIOR TO
03/01/37 AND WAS INCLUDED IN THE
RAILROAD RETIREMENT ACT

1 BENE_IDENT_TB

BENEFICIARY IDENTIFICATION CODE (BIC) TABLE

10 = RETIREMENT - EMPLOYEE OR ANNUITANT
 80 = RR PENSIONER (AGE OR DISABILITY)
 14 = SPOUSE OF RR EMPLOYEE OR ANNUITANT
 (HUSBAND OR WIFE)
 84 = SPOUSE OF RR PENSIONER
 43 = CHILD OF RR EMPLOYEE
 13 = CHILD OF RR ANNUITANT
 17 = DISABLED ADULT CHILD OF RR ANNUITANT
 46 = WIDOW/WIDOWER OF RR EMPLOYEE
 16 = WIDOW/WIDOWER OF RR ANNUITANT
 86 = WIDOW/WIDOWER OF RR PENSIONER
 43 = WIDOW OF EMPLOYEE WITH A CHILD IN HER CARE
 13 = WIDOW OF ANNUITANT WITH A CHILD IN HER CARE
 83 = WIDOW OF PENSIONER WITH A CHILD IN HER CARE
 45 = PARENT OF EMPLOYEE
 15 = PARENT OF ANNUITANT
 85 = PARENT OF PENSIONER
 11 = SURVIVOR JOINT ANNUITANT
 (REduced BENEFITS TAKEN TO INSURE BENEFITS
 FOR SURVIVING SPOUSE)

1 BENE_PRMRY_PYR_TB

BENEFICIARY PRIMARY PAYER TABLE

A = WORKING AGED BENE/SPOUSE WITH EMPLOYER
 GROUP HEALTH PLAN (EGHP)
 B = END STAGE RENAL DISEASE (ESRD) BENEFICIARY
 IN THE 18 MONTH COORDINATION PERIOD WITH
 AN EMPLOYER GROUP HEALTH PLAN
 C = CONDITIONAL PAYMENT BY MEDICARE; FUTURE
 REIMBURSEMENT EXPECTED
 D = AUTOMOBILE NO-FAULT (EFF. 4/97; PRIOR
 TO 3/94, ALSO INCLUDED ANY LIABILITY
 INSURANCE)
 E = WORKERS' COMPENSATION
 F = PUBLIC HEALTH SERVICE OR OTHER FEDERAL
 AGENCY (OTHER THAN DEPT. OF VETERANS
 AFFAIRS)
 G = WORKING DISABLED BENE (UNDER AGE 65
 WITH LGHP)
 H = BLACK LUNG
 I = DEPT. OF VETERANS AFFAIRS
 J = ANY LIABILITY INSURANCE

(EFF. 3/94 - 3/97)

L = ANY LIABILITY INSURANCE (EFF. 4/97)
(EFF. 12/90 FOR CARRIER CLAIMS AND 10/93
FOR FI CLAIMS; OBSOLETE FOR ALL CLAIM
TYPES 7/1/96)

M = OVERRIDE CODE: EGHP SERVICES INVOLVED
(EFF. 12/90 FOR CARRIER CLAIMS AND 10/93
FOR FI CLAIMS; OBSOLETE FOR ALL CLAIM
TYPES 7/1/96)

N = OVERRIDE CODE: NON-EGHP SERVICES INVOLVED
(EFF. 12/90 FOR CARRIER CLAIMS AND 10/93
FOR FI CLAIMS; OBSOLETE FOR ALL CLAIM
TYPES 7/1/96)

BLANK = MEDICARE IS PRIMARY PAYER (NOT SURE
OF EFFECTIVE DATE: IN USE 1/91, IF
NOT EARLIER)

T = MSP COST AVOIDED - IEQ CONTRACTOR
(EFF. 7/96 CARRIER CLAIMS ONLY)

U = MSP COST AVOIDED - HMO RATE CELL ADJUST-
MENT CONTRACTOR (EFF. 7/96 CARRIER CLAIMS
ONLY)

V = MSP COST AVOIDED - LITIGATION SETTLEMENT
CONTRACTOR (EFF. 7/96 CARRIER CLAIMS
ONLY)

X = MSP COST AVOIDED OVERRIDE CODE (EFF.
12/90 FOR CARRIER CLAIMS AND 10/93 FOR
FI CLAIMS; OBSOLETE FOR ALL CLAIM TYPES
7/1/96)

PRIOR TO 12/90

Y = OTHER SECONDARY PAYER INVESTIGATION
SHOWS MEDICARE AS PRIMARY PAYER
BENEFICIARY PRIMARY PAYER TABLE

1 BENE_PRMRY_PYR_TB

Z = MEDICARE IS PRIMARY PAYER

NOTE: VALUES C, M, N, Y, Z AND BLANK

INDICATE MEDICARE IS PRIMARY PAYER.
(VALUES Z AND Y WERE USED PRIOR TO
12/90. BLANK WAS SUPPOSE TO BE
EFFECTIVE AFTER 12/90, BUT MAY HAVE
BEEN USED PRIOR TO THAT DATE.)

1

BETOS_TB

BETOS TABLE

M1A = OFFICE VISITS - NEW
M1B = OFFICE VISITS - ESTABLISHED
M2A = HOSPITAL VISIT - INITIAL
M2B = HOSPITAL VISIT - SUBSEQUENT
M2C = HOSPITAL VISIT - CRITICAL CARE
M3 = EMERGENCY ROOM VISIT
M4A = HOME VISIT
M4B = NURSING HOME VISIT
M5A = SPECIALIST - PATHOLOGY
M5B = SPECIALIST - PSYCHIATRY
M5C = SPECIALIST - OPHTHAMOLOGY
M5D = SPECIALIST - OTHER
M6 = CONSULTATIONS
P0 = ANESTHESIA
P1A = MAJOR PROCEDURE - BREAST
P1B = MAJOR PROCEDURE - COLECTOMY
P1C = MAJOR PROCEDURE - CHOLECYSTECTOMY
P1D = MAJOR PROCEDURE - TURP
P1E = MAJOR PROCEDURE - HYSTERCTOMY
P1F = MAJOR PROCEDURE - EXPLOR/DECOMPR/EXCISDISC
P1G = MAJOR PROCEDURE - OTHER
P2A = MAJOR PROCEDURE, CARDIOVASCULAR-CABG
P2B = MAJOR PROCEDURE, CARDIOVASCULAR-ANEURYSM REPAIR
P2C = MAJOR PROCEDURE, CARDIOVASCULAR-THROMBOENDARTERECTOMY
P2D = MAJOR PROCEDURE, CARDIOVASCUALR-CORONARY ANGIOPLASTY (PTCA)
P2E = MAJOR PROCEDURE, CARDIOVASCULAR-PACEMAKER INSERTION
P2F = MAJOR PROCEDURE, CARDIOVASCULAR-OTHER
P3A = MAJOR PROCEDURE, ORTHOPEDIC - HIP FRACTURE REPAIR
P3B = MAJOR PROCEDURE, ORTHOPEDIC - HIP REPLACEMENT
P3C = MAJOR PROCEDURE, ORTHOPEDIC - KNEE REPLACEMENT
P3D = MAJOR PROCEDURE, ORTHOPEDIC - OTHER
P4A = EYE PROCEDURE - CORNEAL TRANSPLANT
P4B = EYE PROCEDURE - CATARACT REMOVAL/LENS INSERTION
P4C = EYE PROCEDURE - RETINAL DETACHMENT

P4D = EYE PROCEDURE - TREATMENT
P4E = EYE PROCEDURE - OTHER
P5A = AMBULATORY PROCEDURES - SKIN
P5B = AMBULATORY PROCEDURES - MUSCULOSKELETAL
P5C = AMBULATORY PROCEDURES - INGUINAL HERNIA REPAIR
P5D = AMBULATORY PROCEDURES - LITHOTRIPSY
P5E = AMBULATORY PROCEDURES - OTHER
P6A = MINOR PROCEDURES - SKIN
P6B = MINOR PROCEDURES - MUSCULOSKELETAL
P6C = MINOR PROCEDURES - OTHER (MEDICARE FEE SCHEDULE)
P6D = MINOR PROCEDURES - OTHER (NON-MEDICARE FEE SCHEDULE)
P7A = ONCOLOGY - RADIATION THERAPY
P7B = ONCOLOGY - OTHER
P8A = ENDOSCOPY - ARTHROSCOPY
P8B = ENDOSCOPY - UPPER GASTROINTESTINAL
P8C = ENDOSCOPY - SIGMOIDOSCOPY
P8D = ENDOSCOPY - COLONOSCOPY
P8E = ENDOSCOPY - CYSTOSCOPY
P8F = ENDOSCOPY - BRONCHOSCOPY
P8G = ENDOSCOPY - LAPAROSCOPIC CHOLECYSTECTOMY
P8H = ENDOSCOPY - LARYNGOSCOPY
P8I = ENDOSCOPY - OTHER
P9A = DIALYSIS SERVICES

1

BETOS_TB

BETOS TABLE

I1A = STANDARD IMAGING - CHEST
I1B = STANDARD IMAGING - MUSCULOSKELETAL
I1C = STANDARD IMAGING - BREAST
I1D = STANDARD IMAGING - CONTRAST GASTROINTESTINAL
I1E = STANDARD IMAGING - NUCLEAR MEDICINE
I1F = STANDARD IMAGING - OTHER
I2A = ADVANCED IMAGING - CAT: HEAD
I2B = ADVANCED IMAGING - CAT: OTHER
I2C = ADVANCED IMAGING - MRI: BRAIN
I2D = ADVANCED IMAGING - MRI: OTHER
I3A = ECHOGRAPHY - EYE
I3B = ECHOGRAPHY - ABDOMEN/PELVIS
I3C = ECHOGRAPHY - HEART
I3D = ECHOGRAPHY - CAROTID ARTERIES
I3E = ECHOGRAPHY - PROSTATE, TRANSRECTAL
I3F = ECHOGRAPHY - OTHER
I4A = IMAGING/PROCEDURE - HEART INCLUDING CARDIAC
CATHETER

I4B = IMAGING/PROCEDURE - OTHER
T1A = LAB TESTS - ROUTINE VENIPUNCTURE (NON-MEDICARE
FEE SCHEDULE)
T1B = LAB TESTS - AUTOMATED GENERAL PROFILES
T1C = LAB TESTS - URINALYSIS
T1D = LAB TESTS - BLOOD COUNTS
T1E = LAB TESTS - GLUCOSE
T1F = LAB TESTS - BACTERIAL CULTURES
T1G = LAB TESTS - OTHER (MEDICARE FEE SCHEDULE)
T1H = LAB TESTS - OTHER (NON-MEDICARE FEE SCHEDULE)
T2A = OTHER TESTS - ELECTROCARDIOGRAMS
T2B = OTHER TESTS - CARDIOVASCULAR STRESS TESTS
T2C = OTHER TESTS - EKG MONITORING
T2D = OTHER TESTS - OTHER
D1A = MEDICAL/SURGICAL SUPPLIES
D1B = HOSPITAL BEDS
D1C = OXYGEN AND SUPPLIES
D1D = WHEELCHAIRS
D1E = OTHER DME
D1F = ORTHOTIC DEVICES
O1A = AMBULANCE
O1B = CHIROPRACTIC
O1C = ENTERAL AND PARENTERAL
O1D = CHEMOTHERAPY
O1E = OTHER DRUGS
O1F = VISION, HEARING AND SPEECH SERVICES
O1G = INFLUENZA IMMUNIZATION
Y1 = OTHER - MEDICARE FEE SCHEDULE
Y2 = OTHER - NON-MEDICARE FEE SCHEDULE
Z1 = LOCAL CODES
Z2 = UNDEFINED CODES

1 CARR_CLM_PMT_DNL_TB

CARRIER CLAIM PAYMENT DENIAL TABLE

0 = DENIED
1 = PHYSICIAN/SUPPLIER
2 = BENEFICIARY
3 = BOTH PHYSICIAN/SUPPLIER AND BENEFICIARY
4 = HOSPITAL (HOSPITAL BASED PHYSICIANS)
5 = BOTH HOSPITAL AND BENEFICIARY
6 = GROUP PRACTICE PREPAYMENT PLAN
7 = OTHER ENTRIES (E.G. EMPLOYER, UNION)

8 = FEDERALLY FUNDED
9 = PA SERVICE
A = BENEFICIARY UNDER LIMITATION OF
LIABILITY
B = PHYSICIAN/SUPPLIER UNDER LIMITATION OF
LIABILITY
D = DENIED DUE TO DEMONSTRATION INVOLVEMENT
(EFF. 5/97)
E = MSP COST AVOIDED IRS/SSA/HCFA DATA
MATCH (EFF. 7/3/00)
F = MSP COST AVOIDED HMO RATE CELL
(EFF. 7/3/00)
G = MSP COST AVOIDED LITIGATION SETTLEMENT
(EFF. 7/3/00)
H = MSP COST AVOIDED EMPLOYER VOLUNTARY
REPORTING (EFF. 7/3/00)
J = MSP COST AVOIDED INSURER VOLUNTARY
REPORTING (EFF. 7/3/00)
K = MSP COST AVOIDED INITIAL ENROLLMENT
QUESTIONNAIRE (EFF. 7/3/00)
P = PHYSICIAN OWNERSHIP DENIAL (EFF 3/92)
Q = MSP COST AVOIDED - (CONTRACTOR #88888)
VOLUNTARY AGREEMENT (EFF. 1/98)
T = MSP COST AVOIDED - IEQ CONTRACTOR
(EFF. 7/96) (OBSOLETE 6/30/00)
U = MSP COST AVOIDED - HMO RATE CELL
ADJUSTMENT (EFF. 7/96) (OBSOLETE 6/30/00)
V = MSP COST AVOIDED - LITIGATION
SETTLEMENT (EFF. 7/96) (OBSOLETE 6/30/00)
X = MSP COST AVOIDED - GENERIC
Y = MSP COST AVOIDED - IRS/SSA DATA
MATCH PROJECT (OBSOLETE 6/30/00)

1 CARR_LINE_PRVDR_TYPE_TB

CARRIER LINE PROVIDER TYPE TABLE

FOR PHYSICIAN/SUPPLIER (RIC O) CLAIMS:

0 = CLINICS, GROUPS, ASSOCIATIONS,
PARTNERSHIPS, OR OTHER ENTITIES
1 = PHYSICIANS OR SUPPLIERS REPORTING AS
SOLO PRACTITIONERS
2 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)

- 3 = INSTITUTIONAL PROVIDER
- 4 = INDEPENDENT LABORATORIES
- 5 = CLINICS (MULTIPLE SPECIALTIES)
- 6 = GROUPS (SINGLE SPECIALTY)
- 7 = OTHER ENTITIES

FOR DMERC (RIC M) CLAIMS - PRIOR TO VERSION H:

- 0 = CLINICS, GROUPS, ASSOCIATIONS,
PARTNERSHIPS, OR OTHER ENTITIES
FOR WHOM THE CARRIER'S OWN ID NUMBER
HAS BEEN ASSIGNED.
- 1 = PHYSICIANS OR SUPPLIERS BILLING AS
SOLO PRACTITIONERS FOR WHOM SSN'S ARE
SHOWN IN THE PHYSICIAN ID CODE FIELD.
- 2 = PHYSICIANS OR SUPPLIERS BILLING AS
SOLO PRACTITIONERS FOR WHOM THE CARRIER'S
OWN PHYSICIAN ID CODE IS SHOWN.
- 3 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
FOR WHOM EI NUMBERS ARE USED IN CODING THE
ID FIELD.
- 4 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
FOR WHOM THE CARRIER'S OWN CODE HAS BEEN
SHOWN.
- 5 = INSTITUTIONAL PROVIDERS AND
INDEPENDENT LABORATORIES FOR WHOM EI
NUMBERS ARE USED IN CODING THE ID FIELD.
- 6 = INSTITUTIONAL PROVIDERS AND
INDEPENDENT LABORATORIES FOR WHOM THE
CARRIER'S OWN ID NUMBER IS SHOWN.
- 7 = CLINICS, GROUPS, ASSOCIATIONS, OR
PARTNERSHIPS FOR WHOM EI NUMBERS
ARE USED IN CODING THE ID FIELD.
- 8 = OTHER ENTITIES FOR WHOM EI NUMBERS
ARE USED IN CODING THE ID FIELD OR
PROPRIETORSHIP FOR WHOM EI NUMBERS ARE
USED IN CODING THE ID FIELD.

1CARR_LINE_RDCD_PHYSN_ASTNT_TB

CARRIER LINE PART B REDUCED PHYSICIAN ASSISTANT TABLE

BLANK = ADJUSTMENT SITUATION (WHERE
CLM_DISP_CD EQUAL 3)

- 0 = N/A
- 1 = 65%
 - A) PHYSICIAN ASSISTANTS ASSISTING IN SURGERY
 - B) NURSE MIDWIVES
- 2 = 75%
 - A) PHYSICIAN ASSISTANTS PERFORMING SERVICES IN A HOSPITAL (OTHER THAN ASSISTING SURGERY)
 - B) NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS PERFORMING SERVICES IN RURAL AREAS
 - C) CLINICAL SOCIAL WORKER SERVICES
- 3 = 85%
 - A) PHYSICIAN ASSISTANT SERVICES FOR OTHER THAN ASSISTING SURGERY
 - B) NURSE PRACTITIONERS SERVICES

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CARR_NUM_TB

CARRIER NUMBER TABLE

00510 = ALABAMA BS (EFF. 1983)
 00511 = GEORGIA - ALABAMA BS (EFF. 1998)
 00512 = MISSISSIPPI - ALABAMA BS (EFF. 2000)
 00520 = ARKANSAS BS (EFF. 1983)
 00521 = NEW MEXICO - ARKANSAS BS (EFF. 1998)
 00522 = OKLAHOMA - ARKANSAS BS (EFF. 1998)
 00523 = MISSOURI - ARKANSAS BS (EFF. 1999)
 00528 = LOUISIANNA - ARKANSAS BS (EFF. 1984)
 00542 = CALIFORNIA BS (EFF. 1983; TERM. 1996)
 00550 = COLORADO BS (EFF. 1983; TERM. 1994)
 00570 = DELAWARE - PENNSYLVANIA BS (EFF. 1983;
 TERM. 1997)
 00580 = DISTRICT OF COLUMBIA - PENNSYLVANIA BS
 (EFF. 1983; TERM. 1997)
 00590 = FLORIDA BS (EFF. 1983)
 00591 = CONNECTICUT - FLORIDA BS (EFF. 2000)
 00621 = ILLINOIS BS - HCSC (EFF. 1983; TERM. 1998)
 00623 = MICHIGAN - ILLINOIS BLUE SHIELD (EFF. 1995)
 (TERM. 1998)
 00630 = INDIANA - ADMINISTAR (EFF. 1983)
 00635 = DMERC-B (ADMINISTAR FEDERAL, INC.)
 (EFF. 1993)

00640 = IOWA - WELLMARK, INC. (EFF. 1983; TERM. 1998)
00645 = NEBRASKA - IOWA BS (EFF. 1985; TERM. 1987)
00650 = KANSAS BS (EFF. 1983)
00655 = NEBRASKA - KANSAS BS (EFF. 1988)
00660 = KENTUCKY - ADMINISTAR (EFF. 1983)
00690 = MARYLAND BS (EFF. 1983; TERM. 1994)
00700 = MASSACHUSETTS BS (EFF. 1983; TERM. 1997)
00710 = MICHIGAN BS (EFF. 1983; TERM. 1994)
00720 = MINNESOTA BS (EFF. 1983; TERM. 1995)
00740 = MISSOURI - BS KANSAS CITY (EFF. 1983)
00751 = MONTANA BS (EFF. 1983)
00770 = NEW HAMPSHIRE/VERMONT PHYSICIAN SERVICES
(EFF. 1983; TERM. 1984)
00780 = NEW HAMPSHIRE/VERMONT - MASSACHUSETTS BS
(EFF. 1985; TERM. 1997)
00801 = NEW YORK - WESTERN BS (EFF. 1983)
00803 = NEW YORK - EMPIRE BS (EFF. 1983)
00805 = NEW JERSEY - EMPIRE BS (EFF. 3/99)
00811 = DMERC (A) - WESTERN NEW YORK BS (EFF. 2000)
00820 = NORTH DAKOTA - NORTH DAKOTA BS (EFF. 1983)
00824 = COLORADO - NORTH DAKOTA BS (EFF. 1995)
00825 = WYOMING - NORTH DAKOTA BS (EFF. 1990)
00826 = IOWA - NORTH DAKOTA BS (EFF. 1999)
00831 = ALASKA - NORTH DAKOTA BS (EFF. 1998)
00832 = ARIZONA - NORTH DAKOTA BS (EFF. 1998)
00833 = HAWAII - NORTH DAKOTA BS (EFF. 1998)
00834 = NEVADA - NORTH DAKOTA BS (EFF. 1998)
00835 = OREGON - NORTH DAKOTA BS (EFF. 1998)
00836 = WASHINGTON - NORTH DAKOTA BS (EFF. 1998)
00860 = NEW JERSEY - PENNSYLVANIA BS (EFF. 1988;
TERM. 1999)
00865 = PENNSYLVANIA BS (EFF. 1983)
00870 = RHODE ISLAND BS (EFF. 1983)
00880 = SOUTH CAROLINA BS (EFF. 1983)
00882 = RRB - SOUTH CAROLINA PGBA (EFF. 2000)

CARRIER NUMBER TABLE

00885 = DMERC C - PALMETTO (EFF. 1993)
00900 = TEXAS BS (EFF. 1983)
00901 = MARYLAND - TEXAS BS (EFF. 1995)
00902 = DELAWARE - TEXAS BS (EFF. 1998)
00903 = DISTRICT OF COLUMBIA - TEXAS BS (EFF. 1998)
00904 = VIRGINIA - TEXAS BS (EFF. 2000)

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CARR_NUM_TB

00910 = UTAH BS (EFF. 1983)
00951 = WISCONSIN - WISCONSIN PHY SVC (EFF. 1983)
00952 = ILLINOIS - WISCONSIN PHY SVC (EFF. 1999)
00953 = MICHIGAN - WISCONSIN PHY SVC (EFF. 1999)
00954 = MINNESOTA - WISCONSIN PHY SVC (EFF. 2000)
00973 = TRIPLE-S, INC. - PUERTO RICO (EFF. 1983)
00974 = TRIPLE-S, INC. - VIRGIN ISLANDS
01020 = ALASKA - AETNA (EFF. 1983; TERM. 1997)
01030 = ARIZONA - AETNA (EFF. 1983; TERM. 1997)
01040 = GEORGIA - AETNA (EFF. 1988; TERM. 1997)
01120 = HAWAII - AETNA (EFF. 1983; TERM. 1997)
01290 = NEVADA - AETNA (EFF. 1983; TERM. 1997)
01360 = NEW MEXICO - AETNA (EFF. 1986; TERM. 1997)
01370 = OKLAHOMA - AETNA (EFF. 1983; TERM. 1997)
01380 = OREGON - AETNA (EFF. 1983; TERM. 1997)
01390 = WASHINGTON - AETNA (EFF. 1994; TERM. 1997)
02050 = CALIFORNIA - TOLIC (EFF. 1983)
(TERM. 2000)
03070 = CONNECTICUT GENERAL LIFE INSURANCE CO.
(EFF. 1983; TERM. 1985)
05130 = IDAHO - CONNECTICUT GENERAL (EFF. 1983)
05320 = NEW MEXICO - EQUITABLE INSURANCE
(EFF. 1983; TERM. 1985)
05440 = TENNESSEE - CONNECTICUT GENERAL (EFF. 1983)
05530 = WYOMING - EQUITABLE INSURANCE (EFF. 1983)
(TERM. 1989)
05535 = NORTH CAROLINA - CONNECTICUT GENERAL
(EFF. 1988)
05655 = DMERC-D - CONNECTICUT GENERAL (EFF. 1993)
10071 = RAILROAD BOARD TRAVELERS (EFF. 1983)
(TERM. 2000)
10230 = CONNECTICUT - METRA HEALTH (EFF. 1986)
(TERM. 2000)
10240 = MINNESOTA - METRA HEALTH (EFF. 1983)
(TERM. 2000)
10250 = MISSISSIPPI - METRA HEALTH (EFF. 1983)
(TERM. 2000)
10490 = VIRGINIA - METRA HEALTH (EFF. 1983)
(TERM. 2000)
10555 = TRAVELERS INSURANCE CO. (EFF. 1993)
(TERM. 2000)
11260 = MISSOURI - GENERAL AMERICAN LIFE
(EFF. 1983; TERM. 1998)
14330 = NEW YORK - GHI (EFF. 1983)

16360 = OHIO - NATIONWIDE INSURANCE CO.
16510 = WEST VIRGINIA - NATIONWIDE INSURANCE CO.
21200 = MAINE - BS OF MASSACHUSETTS
31140 = CALIFORNIA - NATIONAL HERITAGE INS.
31142 = MAINE - NATIONAL HERITAGE INS.
31143 = MASSACHUSETTS - NATIONAL HERITAGE INS.
31144 = NEW HAMPSHIRE - NATIONAL HERITAGE INS.
31145 = VERMONT - NATIONAL HERITAGE INS.

1 CARR_NUM_TB

CARRIER NUMBER TABLE

31146 = SO. CALIFORNIA - NHIC (EFF. 2000)

1 CLM_BILL_TYPE_TB

CLAIM BILL TYPE TABLE

11 = HOSPITAL-INPATIENT (INCLUDING PART A)
12 = HOSPITAL-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
13 = HOSPITAL-OUTPATIENT (HHA-A ALSO) (UNDER OPPTS 13X
MUST BE USED FOR ASC CLAIMS SUBMITTED FOR OPPTS
PAYMENT -- EFF. 7/00)
14 = HOSPITAL-OTHER (PART B)
15 = HOSPITAL-INTERMEDIATE CARE - LEVEL I
16 = HOSPITAL-INTERMEDIATE CARE - LEVEL II
17 = HOSPITAL-INTERMEDIATE CARE - LEVEL III
18 = HOSPITAL-SWING BEDS
19 = HOSPITAL-RESERVED FOR NATIONAL ASSIGNMENT
21 = SNF-INPATIENT (INCLUDING PART A)
22 = SNF-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
23 = SNF-OUTPATIENT (HHA-A ALSO)
24 = SNF-OTHER (PART B)
25 = SNF-INTERMEDIATE CARE - LEVEL I
26 = SNF-INTERMEDIATE CARE - LEVEL II
27 = SNF-INTERMEDIATE CARE - LEVEL III
28 = SNF-SWING BEDS
29 = SNF-RESERVED FOR NATIONAL ASSIGNMENT
31 = HHA-INPATIENT (INCLUDING PART A)
32 = HHA-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
33 = HHA-OUTPATIENT (HHA-A ALSO)
34 = HHA-OTHER (PART B)
35 = HHA-INTERMEDIATE CARE - LEVEL I
36 = HHA-INTERMEDIATE CARE - LEVEL II
37 = HHA-INTERMEDIATE CARE - LEVEL III

38 = HHA-SWING BEDS
39 = HHA-RESERVED FOR NATIONAL ASSIGNMENT
41 = RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION (RNHCI)
HOSPITAL-INPATIENT (INCLUDING PART A) (ALL REFERENCES
TO CHRISTIAN SCIENCE (CS) IS OBSOLETE EFF. 8/00 AND
REPLACED WITH RNHCI)
42 = RNHCI HOSPITAL-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
43 = RNHCI HOSPITAL-OUTPATIENT (HHA-A ALSO)
44 = RNHCI HOSPITAL-OTHER (PART B)
45 = RNHCI HOSPITAL-INTERMEDIATE CARE - LEVEL I
46 = RNHCI HOSPITAL-INTERMEDIATE CARE - LEVEL II
47 = RNHCI HOSPITAL-INTERMEDIATE CARE - LEVEL III
48 = RNHCI HOSPITAL-SWING BEDS
49 = RNHCI HOSPITAL-RESERVED FOR NATIONAL ASSIGNMENT
51 = CS EXTENDED CARE-INPATIENT (INCLUDING PART A) OBSOLETE
EFF. 7/00 - IMPLEMENTATION OF RELIGIOUS NONMEDICAL
HEALTH CARE INSTITUTIONS (RNHCI)
52 = RNHCI EXTENDED CARE-INPATIENT OR HOME HEALTH VISITS
(PART B ONLY) (EFF. 7/00); PRIOR TO 7/00 CHRISTIAN SCIENCE (CS)
53 = RNHCI EXTENDED CARE-OUTPATIENT (HHA-A ALSO) (EFF. 7/00);
PRIOR TO 7/00 REFERENCED CS
54 = RNHCI EXTENDED CARE-OTHER (PART B) (EFF. 7/00); PRIOR
TO 7/00 REFERENCED CS
55 = RNHCI EXTENDED CARE-INTERMEDIATE CARE - LEVEL I (EFF. 7/00)
PRIOR TO 7/00 REFERENCED CS
56 = RNHCI EXTENDED CARE-INTERMEDIATE CARE - LEVEL II (EFF. 7/00)
PRIOR TO 7/00 REFERENCED CS
57 = RNHCI EXTENDED CARE-INTERMEDIATE CARE - LEVEL III (EFF. 7/00)
PRIOR TO 7/00 REFERENCED CS
58 = RNHCI EXTENDED CARE-SWING BEDS (EFF. 7/00)
CLAIM BILL TYPE TABLE

1 CLM_BILL_TYPE_TB

PRIOR TO 7/00 REFERENCED CS
59 = RNHCI EXTENDED CARE-RESERVED FOR NATIONAL ASSIGNMENT
(EFF. 7/00); PRIOR TO 7/00 REFERENCED CS
61 = INTERMEDIATE CARE-INPATIENT (INCLUDING PART A)
62 = INTERMEDIATE CARE-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
63 = INTERMEDIATE CARE-OUTPATIENT (HHA-A ALSO)
64 = INTERMEDIATE CARE-OTHER (PART B)
65 = INTERMEDIATE CARE-INTERMEDIATE CARE - LEVEL I
66 = INTERMEDIATE CARE-INTERMEDIATE CARE - LEVEL II
67 = INTERMEDIATE CARE-INTERMEDIATE CARE - LEVEL III
68 = INTERMEDIATE CARE-SWING BEDS

69 = INTERMEDIATE CARE-RESERVED FOR NATIONAL ASSIGNMENT
71 = CLINIC-RURAL HEALTH
72 = CLINIC-HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS FACILITY
73 = CLINIC-INDEPENDENT PROVIDER BASED FQHC (EFF 10/91)
74 = CLINIC-ORF ONLY (EFF 4/97);
ORF AND CMHC (10/91 - 3/97)
75 = CLINIC-CORF
76 = CLINIC-CMHC (EFF 4/97)
77 = CLINIC-RESERVED FOR NATIONAL ASSIGNMENT
78 = CLINIC-RESERVED FOR NATIONAL ASSIGNMENT
79 = CLINIC-OTHER
81 = SPECIAL FACILITY OR ASC SURGERY-HOSPICE (NON-HOSPITAL BASED)
82 = SPECIAL FACILITY OR ASC SURGERY-HOSPICE (HOSPITAL BASED)
83 = SPECIAL FACILITY OR ASC SURGERY-AMBULATORY SURGICAL CENTER
(DISCONTINUED FOR HOSPITALS SUBJECT TO OUTPATIENT PPS;
HOSPITALS MUST USE 13X FOR ASC CLAIMS SUBMITTED FOR OPPS
PAYMENT -- EFF. 7/00)
84 = SPECIAL FACILITY OR ASC SURGERY-FREESTANDING BIRTHING CENTER
85 = SPECIAL FACILITY OR ASC SURGERY-RURAL PRIMARY CARE HOSPITAL (EFF
86 = SPECIAL FACILITY OR ASC SURGERY-RESERVED FOR NATIONAL USE
87 = SPECIAL FACILITY OR ASC SURGERY-RESERVED FOR NATIONAL USE
88 = SPECIAL FACILITY OR ASC SURGERY-RESERVED FOR NATIONAL USE
89 = SPECIAL FACILITY OR ASC SURGERY-OTHER
91 = RESERVED-INPATIENT (INCLUDING PART A)
92 = RESERVED-INPATIENT OR HOME HEALTH VISITS (PART B ONLY)
93 = RESERVED-OUTPATIENT (HHA-A ALSO)
94 = RESERVED-OTHER (PART B)
95 = RESERVED-INTERMEDIATE CARE - LEVEL I
96 = RESERVED-INTERMEDIATE CARE - LEVEL II
97 = RESERVED-INTERMEDIATE CARE - LEVEL III
98 = RESERVED-SWING BEDS
99 = RESERVED-RESERVED FOR NATIONAL ASSIGNMENT

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CLM_DISP_TB

CLAIM DISPOSITION TABLE

01 = DEBIT ACCEPTED
02 = DEBIT ACCEPTED (AUTOMATIC ADJUSTMENT)
APPLICABLE THROUGH 4/4/93
03 = CANCEL ACCEPTED
61 = *CONVERSION CODE: DEBIT ACCEPTED
62 = *CONVERSION CODE: DEBIT ACCEPTED
(AUTOMATIC ADJUSTMENT)

63 = *CONVERSION CODE: CANCEL ACCEPTED

*USED ONLY DURING CONVERSION PERIOD:
1/1/91 - 2/21/91

1 CLM_FAC_TYPE_TB

CLAIM FACILITY TYPE TABLE

1 = HOSPITAL
2 = SKILLED NURSING FACILITY (SNF)
3 = HOME HEALTH AGENCY (HHA)
4 = RELIGIOUS NONMEDICAL (HOSPITAL)
(EFF. 8/1/00); PRIOR TO 8/00 REFERENCED CHRISTIAN
SCIENCE (CS)
5 = RELIGIOUS NONMEDICAL (EXTENDED CARE)
(EFF. 8/1/00); PRIOR TO 8/00 REFERENCED CS
6 = INTERMEDIATE CARE
7 = CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY
8 = SPECIAL FACILITY OR ASC SURGERY
9 = RESERVED

1 CLM_FREQ_TB

CLAIM FREQUENCY TABLE

0 = NON-PAYMENT/ZERO CLAIMS
1 = ADMIT THRU DISCHARGE CLAIM
2 = INTERIM - FIRST CLAIM
3 = INTERIM - CONTINUING CLAIM
4 = INTERIM - LAST CLAIM
5 = LATE CHARGE(S) ONLY CLAIM
6 = ADJUSTMENT OF PRIOR CLAIM
7 = REPLACEMENT OF PRIOR CLAIM;
EFF 10/93, PROVIDER DEBIT
8 = VOID/CANCEL PRIOR CLAIM.
EFF 10/93, PROVIDER CANCEL
9 = FINAL CLAIM -- USED IN AN HH PPS
EPISODE TO INDICATE THE CLAIM
SHOULD BE PROCESSED LIKE DEBIT/
CREDIT ADJUSTMENT TO RAP (INITIAL
CLAIM) (EFF. 10/00)
A = ADMISSION NOTICE - USED WHEN HOSPICE
IS SUBMITTING THE HCFA-1450 AS AN

ADMISSION NOTICE - HOSPICE NOE ONLY
 B = HOSPICE TERMINATION/REVOCATION NOTICE
 - HOSPICE NOE ONLY (EFF 9/93)
 C = HOSPICE CHANGE OF PROVIDER NOTICE
 - HOSPICE NOE ONLY (EFF 9/93)
 D = HOSPICE ELECTION VOID/CANCEL
 - HOSPICE NOE ONLY (EFF 9/93)
 E = HOSPICE CHANGE OF OWNERSHIP
 - HOSPICE NOE ONLY (EFF 1/97)
 F = BENEFICIARY INITIATED ADJUSTMENT
 (EFF 10/93)
 G = CWF GENERATED ADJUSTMENT (EFF 10/93)
 H = HCFA GENERATED ADJUSTMENT (EFF 10/93)
 I = MISC ADJUSTMENT CLAIM (OTHER THAN PRO
 OR PROVIDER) - USED TO IDENTIFY A
 DEBIT ADJUSTMENT INITIATED BY HCFA OR
 AN INTERMEDIARY - EFF 10/93, USED TO
 IDENTIFY INTERMEDIARY INITIATED
 ADJUSTMENT ONLY
 J = OTHER ADJUSTMENT REQUEST (EFF 10/93)
 K = OIG INITIATED ADJUSTMENT (EFF 10/93)
 M = MSP ADJUSTMENT (EFF 10/93)
 P = ADJUSTMENT REQUIRED BY PEER REVIEW
 ORGANIZATION (PRO)
 X = SPECIAL ADJUSTMENT PROCESSING - USED
 FOR QA EDITING (EFF 8/92)
 Z = HOSPITAL ENCOUNTER DATA ALTERNATE SUB-
 MISSION (TOB '11Z') USED FOR MCO ENROLLEE
 HOSPITAL DISCHARGES 7/1/97-12/31/98; NOT
 STORED IN NCH. EXCEPTION: PROBLEM IN
 STARTUP MONTHS MAY HAVE RESULTED IN THIS
 ABBREVIATED UB-92 BEING ERRONEOUSLY
 STORED IN NCH.

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CLM_HHA_RFRL_TB

CLAIM HOME HEALTH REFERRAL TABLE

- 1 = PHYSICIAN REFERRAL - THE PATIENT WAS
 ADMITTED UPON THE RECOMMENDATION OF
 A PERSONAL PHYSICIAN.
 2 = CLINIC REFERRAL - THE PATIENT WAS
 ADMITTED UPON THE RECOMMENDATION OF
 THIS FACILITY'S CLINIC PHYSICIAN.

- 3 = HMO REFERRAL - THE PATIENT WAS ADMITTED UPON THE RECOMMENDATION OF AN HEALTH MAINTENANCE ORGANIZATION (HMO) PHYSICIAN.
- 4 = TRANSFER FROM HOSPITAL - THE PATIENT WAS ADMITTED AS AN INPATIENT TRANSFER FROM AN ACUTE CARE FACILITY.
- 5 = TRANSFER FROM A SKILLED NURSING FACILITY (SNF) - THE PATIENT WAS ADMITTED AS AN INPATIENT TRANSFER FROM A SNF.
- 6 = TRANSFER FROM ANOTHER HEALTH CARE FACILITY - THE PATIENT WAS ADMITTED AS A TRANSFER FROM A HEALTH CARE FACILITY OTHER THAN AN ACUTE CARE FACILITY OR SNF.
- 7 = EMERGENCY ROOM - THE PATIENT WAS ADMITTED UPON THE RECOMMENDATION OF THIS FACILITY'S EMERGENCY ROOM PHYSICIAN.
- 8 = COURT/LAW ENFORCEMENT - THE PATIENT WAS ADMITTED UPON THE DIRECTION OF A COURT OF LAW OR UPON THE REQUEST OF A LAW ENFORCEMENT AGENCY'S REPRESENTATIVE.
- 9 = INFORMATION NOT AVAILABLE - THE MEANS BY WHICH THE PATIENT WAS ADMITTED IS NOT KNOWN.
- A = TRANSFER FROM A CRITICAL ACCESS HOSPITAL - PATIENT WAS ADMITTED/REFERRED TO THIS FACILITY AS A TRANSFER FROM A CRITICAL ACCESS HOSPITAL.
- B = TRANSFER FROM ANOTHER HHA - BENEFICIARIES ARE PERMITTED TO TRANSFER FROM ONE HHA TO ANOTHER UNRELATED HHA UNDER HH PPS. (EFF. 10/00)
- C = READMISSION TO SAME HHA - IF A BENEFICIARY IS DISCHARGED FROM AN HHA AND THEN RE-ADMITTED WITHIN THE ORIGINAL 60-DAY EPISODE, THE ORIGINAL EPISODE MUST BE CLOSED EARLY AND A NEW ONCE CREATED. NOTE: THE USE OF THIS CODE WILL PERMIT THE AGENCY TO SEND A NEW RAP ALLOWING ALL CLAIMS TO BE ACCEPTED BY MEDICARE.

(EFF. 10/00)

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CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE

PPS TABLE

***** SNF PPS HIPPS *****
*****1ST 3 POSITIONS (RUGS-III GROUP)*****
AAA = DEFAULT: NO ASSESSMENT

BA1,BA2,BB1,BB2 = BEHAVIOR ONLY PROBLEMS (E.G.,
PHYSICAL/VERBAL ABUSE)

CA1,CA2,CB1,CB2 = CLINICALLY-COMPLEX CONDITIONS
CC1,CC2 (E.G., CHEMO, DIALYSIS)

IA1,IA2,IB1,IB2 = IMPAIRED COGNITION (E.G., IM-
PAIRED COGNITION (E.G., SHORT-
TERM MEMORY)

PA1,PA2,PB1,PB2 = REDUCED PHYSICAL FUNCTIONS
PC1,PC2,PD1,PD2
PE1,PE2

RHA,RHB,RHC,RLA = LOW/MEDIUM/HIGH REHABILITATION
RLB,RMA,RMB,RMC

RUA,RUB,RUC,RVA = VERY HIGH/ULTRA HIGH REHABILITA-
RVB,RVC TION: HIGHEST LEVEL

SE1,SE2,SE3 = EXTENSIVE SERVICES; E.G.; IV FEED
TRACH CARE

SSA,SSB,SSC = SPECIAL CARE; E.G.; COMA, BURNS

*****POSITIONS 4 & 5 REPRESENT HIPPS MODIFIER/*****
***** ASSESSMENT TYPE INDICATOR *****

00 = NO ASSESSMENT COMPLETED
01 = MEDICARE 5-DAY FULL ASSESSMENT/NOT AN INITIAL
ADMISSION ASSESSMENT
02 = MEDICARE 30-DAY FULL ASSESSMENT
03 = MEDICARE 60-DAY FULL ASSESSMENT
04 = MEDICARE 90-DAY FULL ASSESSMENT

05 = MEDICARE READMISSION/RETURN REQUIRED ASSESSMENT
(EFF. 10/2000)

07 = MEDICARE 14-DAY FULL OR COMPREHENSIVE ASSESSMENT/
NOT AN INITIAL ADMISSION ASSESSMENT

08 = OFF-CYCLE OTHER MEDICARE REQUIRED ASSESSMENT (OMRA)

11 = ADMISSION ASSESSMENT AND MEDICARE 5-DAY (OR READMISSION/
RETURN) ASSESSMENT

17 = MEDICARE 14-DAY REQUIRED ASSESSMENT AND INITIAL
ADMISSION ASSESSMENT (EFF. 10/2000)

18 = OMRA REPLACING MEDICARE 5-DAY REQUIRED ASSESSMENT
(EFF. 10/2000)

28 = OMRA REPLACING MEDICARE 30-DAY REQUIRED ASSESSMENT
(EFF. 10/2000)

30 = OFF-CYCLE SIGNIFICANT CHANGE ASSESSMENT (OUTSIDE
ASSESSMENT WINDOW) (EFF. 10/2000)

31 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
5-DAY ASSESSMENT (EFF. 10/2000)

32 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
30-DAY ASSESSMENT

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CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE PPS TABLE

33 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
6--DAY ASSESSMENT

34 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
90-DAY ASSESSMENT

35 = SIGNIFICANT CHANGE ASSESSMENT REPLACES A MEDICARE
READMISSION/RETURN ASSESSMENT

37 = SIGNIFICANT CHANGE ASSESSMENT REPLACES MEDICARE
14-DAY ASSESSMENT

38 = OMRA REPLACING MEDICARE 60-DAY REQUIRED
ASSESSMENT

40 = OFF-CYCLE SIGNIFICANT CORRECTION ASSESSMENT OF A
PRIOR ASSESSMENT (OUTSIDE ASSESSMENT WINDOW)
(EFF. 10/2000)

41 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
REPLACES A MEDICARE 5-DAY ASSESSMENT

42 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
REPLACES A MEDICARE 30-DAY ASSESSMENT

43 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
REPLACES A MEDICARE 60-DAY ASSESSMENT

44 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
REPLACES A MEDICARE 90-DAY ASSESSMENT

45 = SIGNIFICANT CORRECTION OF A PRIOR ASSESSMENT

REPLACES A READMISSION/RETURN ASSESSMENT
(EFF. 10/2000)
47 = SIGNIFICANT CORRECTION OF PRIOR FULL ASSESSMENT
REPLACES A MEDICARE 14-DAY REQUIRED ASSESSMENT
48 = OMRA REPLACING MEDICARE 90-DAY REQUIRED ASSESSMENT
54 = QUARTERLY REVIEW ASSESSMENT - MEDICARE 90-DAY
FULL ASSESSMENT
78 = OMRA REPLACING A MEDICARE 14-DAY ASSESSMENT
(EFF. 10/2000)

*****CLAIM HOME HEALTH PPS HIPPS TABLE*****
***** KEY *****

POSITION 1 = 'H'
POSITION 2 = CLINICAL (A, B, C, D)
POSITION 3 = FUNCTIONAL (E, F, G, H, I)
POSITION 4 = SERVICE (J, K, K, M)
POSITION 5 = IDENTIFIES WHICH ELEMENTS OF THE CODE WERE
COMPUTED OR DERIVED:
1 = 2ND, 3RD, 4TH POSITIONS COMPUTED
2 = 2ND POSITION DERIVED
3 = 3RD POSITION DERIVED
4 = 4TH POSITION DERIVED
5 = 2ND & 3RD POSITIONS DERIVED
6 = 3RD & 4TH POSITIONS DERIVED
7 = 2ND & 4TH POSITIONS DERIVED
8 = 2ND, 3RD, 4TH POSITIONS DERIVED

HHRG = C0F0S0/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = MIN
HAEJ1
HAEJ2
HAEJ3

1 CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE PPS TABLE

HAEJ4
HAEJ5
HAEJ6
HAEJ7
HAEJ8

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**HHRG = C0F0S1/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = LOW**
HAEK1
HAEK2
HAEK3
HAEK4
HAEK5
HAEK6
HAEK7
HAEK8
**HHRG = C0F0S2/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = MOD**
HAEL1
HAEL2
HAEL3
HAEL4
HAEL5
HAEL6
HAEL7
HAEL8
**HHRG = C0F0S3/CLINICAL = MIN, FUNCTIONAL = MIN, SERVICE = HIGH**
HAEM1
HAEM2
HAEM3
HAEM4
HAEM5
HAEM6
HAEM7
HAEM8
**HHRG = C0F1S0/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = MIN**
HAFJ1
HAFJ2
HAFJ3
HAFJ4
HAFJ5
HAFJ6
HAFJ7
HAFJ8
**HHRG = C0F1S1/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = LOW**
HAFK1
HAFK2
HAFK3
HAFK4
HAFK5
HAFK6
HAFK7
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CLM_HIPPS_TB

HAFK8
HHRG = C0F1S2/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = MOD
HAFL1
HAFL2
HAFL3
HAFL4
HAFL5
HAFL6
HAFL7

CLAIM SNF & HHA HEALTH INSURANCE

PPS TABLE

HAFL8
HHRG = C0F1S3/CLINICAL = MIN, FUNCTIONAL = LOW, SERVICE = HIGH
HAFM1
HAFM2
HAFM3
HAFM4
HAFM5
HAFM6
HAFM7
HAFM8
HHRG = C0F2S0/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = MIN
HAGJ1
HAGJ2
HAGJ3
HAGJ4
HAGJ5
HAGJ6
HAGJ7
HAGJ8
HHRG = C0F2S1/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = LOW
HAGK1
HAGK2
HAGK3
HAGK4
HAGK5
HAGK6
HAGK7
HAGK8
HHRG = C0F2S2/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = MOD
HAGL1
HAGL2
HAGL3

HAGL4
HAGL5
HAGL6
HAGL7
HAGL8
HHRG = C0F2S3/CLINICAL = MIN, FUNCTIONAL = MOD, SERVICE = HIGH
HAGM1
HAGM2
HAGM3
HAGM4
HAGM5
HAGM6
HAGM7
HAGM8
HHRG = C0F3S0/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = MIN
HAHJ1
HAHJ2
HAHJ3
HAHJ4
HAHJ5
HAHJ6
HAHJ7
HAHJ8
HHRG = C0F3S1/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = LOW
HAHK1
HAHK2

1

CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE

PPS TABLE

HAHK3
HAHK4
HAHK5
HAHK6
HAHK7
HAHK8
HHRG = C0F3S2/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = MOD
HAHL1
HAHL2
HAHL3
HAHL4
HAHL5
HAHL6
HAHL7
HAHL8

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**HHRG = C0F3S3/CLINICAL = MIN, FUNCTIONAL = HIGH, SERVICE = HIGH**
HAHM1
HAHM2
HAHM3
HAHM4
HAHM5
HAHM6
HAHM7
HAHM8
**HHRG = C0F4S0/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = MIN**
HAIJ1
HAIJ2
HAIJ3
HAIJ4
HAIJ5
HAIJ6
HAIJ7
HAIJ8
**HHRG = C0F4S1/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = LOW**
HAIK1
HAIK2
HAIK3
HAIK4
HAIK5
HAIK6
HAIK7
HAIK8
**HHRG = C0F4S2/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = MOD**
HAIL1
HAIL2
HAIL3
HAIL4
HAIL5
HAIL6
HAIL7
HAIL8
**HHRG = C0F4S3/CLINICAL = MIN, FUNCTIONAL = MAX, SERVICE = HIGH**
HAIM1
HAIM2
HAIM3
HAIM4
HAIM5
HAIM6
```

HAIM7
HAIM8
HHRG = C1F0S0/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = MIN
HBEJ1
HBEJ2
HBEJ3
HBEJ4
HBEJ5
HBEJ6
HBEJ7
HBEJ8
HHRG = C1F0S1/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = LOW
HBEK1
HBEK2
HBEK3
HBEK4
HBEK5
HBEK6
HBEK7
HBEK8
HHRG = C1F0S2/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = MOD
HBEL1
HBEL2
HBEL3
HBEL4
HBEL5
HBEL6
HBEL7
HBEL8
HHRG = C1F0S3/CLINICAL = LOW, FUNCTIONAL = MIN, SERVICE = HIGH
HBEM1
HBEM2
HBEM3
HBEM4
HBEM5
HBEM6
HBEM7
HBEM8
HHRG = C1F1S0/CLINICAL = LOW, FUNCTIONAL = LOW, SERVICE = MIN
HBFJ1
HBFJ2
HBFJ3

1	CLM_HIPPS_TB -----	HBFL1 CLAIM SNF & HHA HEALTH INSURANCE -----	PPS TABLE
		HBFL2	
		HBFL3	
		HBFL4	
		HBFL5	
		HBFL6	
		HBFL7	
		HBFL8	
		HHRG = C1F1S3/CLINICAL = LOW, FUNCTIONAL = LOW, SERVICE = HIGH	
		HBFL1	
		HBFL2	
		HBFL3	
		HBFL4	
		HBFL5	
		HBFL6	
		HBFL7	
		HBFL8	
		HHRG = C1F2S0/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = MIN	
		HBFL1	
		HBFL2	
		HBFL3	
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**HHRG = C1F2S1/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = LOW**
HBGK1
HBGK2
HBGK3
HBGK4
HBGK5
HBGK6
HBGK7
HBGK8
**HHRG = C1F2S2/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = MOD**
HBGL1
HBGL2
HBGL3
HBGL4
HBGL5
HBGL6
HBGL7
HBGL8
**HHRG = C1F2S3/CLINICAL = LOW, FUNCTIONAL = MOD, SERVICE = HIGH**
HBGM1
HBGM2
HBGM3
HBGM4
HBGM5
HBGM6
HBGM7
HBGM8
**HHRG = C1F3S0/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = MIN**
HBHJ1
HBHJ2
HBHJ3
HBHJ4
HBHJ5

HBHJ6
HBHJ7
HBHJ8
**HHRG = C1F3S1/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = LOW**
HBHK1
HBHK2
HBHK3
HBHK4
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CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE

PPS TABLE

HBHK5
HBHK6
HBHK7
HBHK8
HHRG = C1F3S2/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = MOD
HBHL1
HBHL2
HBHL3
HBHL4
HBHL5
HBHL6
HBHL7
HBHL8
HHRG = C1F3S3/CLINICAL = LOW, FUNCTIONAL = HIGH, SERVICE = HIGH
HBHM1
HBHM2
HBHM3
HBHM4
HBHM5
HBHM6
HBHM7
HBHM8
HHRG = C1F4S0/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = MIN
HBIJ1
HBIJ2
HBIJ3
HBIJ4
HBIJ5
HBIJ6
HBIJ7
HBIJ8
HHRG = C1F4S1/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = LOW
HBIK1
HBIK2
HBIK3
HBIK4
HBIK5
HBIK6
HBIK7
HBIK8
HHRG = C1F4S2/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = MOD
HBIL1
HBIL2
HBIL3

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CLM_HIPPS_TB

HBIL4
HBIL5
HBIL6
HBIL7
HBIL8

HHRG = C1F4S3/CLINICAL = LOW, FUNCTIONAL = MAX, SERVICE = HIGH
CLAIM SNF & HHA HEALTH INSURANCE PPS TABLE

HBIM1
HBIM2
HBIM3
HBIM4
HBIM5
HBIM6
HBIM7
HBIM8

HHRG = C2F0S0/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = MIN

HCEJ1
HCEJ2
HCEJ3
HCEJ4
HCEJ5
HCEJ6
HCEJ7
HCEJ8

HHRG = C2F0S1/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = LOW

HCEK1
HCEK2
HCEK3
HCEK4
HCEK5
HCEK6
HCEK7
HCEK8

HHRG = C2F0S2/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = MOD

HCEL1
HCEL2
HCEL3
HCEL4
HCEL5
HCEL6
HCEL7
HCEL8

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**HHRG = C2F0S3/CLINICAL = MOD, FUNCTIONAL = MIN, SERVICE = HIGH**
HCEM1
HCEM2
HCEM3
HCEM4
HCEM5
HCEM6
HCEM7
HCEM8
**HHRG = C2F1S0/CLINICAL = MOD, FUNCTIONAL = LOW, SERVICE = MIN**
HCFJ1
HCFJ2
HCFJ3
HCFJ4
HCFJ5
HCFJ6
HCFJ7
HCFJ8
**HHRG = C2F1S2/CLINICAL = MOD, FUNCTIONAL = LOW, SERVICE = MOD**
HCFL1
HCFL2
HCFL3
HCFL4
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1 CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE PPS TABLE

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HCFL5
HCFL6
HCFL7
HCFL8
**HHRG = C2F1S3/CLINICAL = MOD, FUNCTIONAL = LOW, SERVICE = HIGH**
HCFM1
HCFM2
HCFM3
HCFM4
HCFM5
HCFM6
HCFM7
HCFM8
**HHRG = C2F2S0/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = MIN**
HCGJ1
HCGJ2
HCGJ3
HCGJ4
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HCGJ5
HCGJ6
HCGJ7
HCGJ8
HHRG = C2F2S1/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = LOW
HCGK1
HCGK2
HCGK3
HCGK4
HCGK5
HCGK6
HCGK7
HCGK8
HHRG = C2F2S2/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = MOD
HCGL1
HCGL2
HCGL3
HCGL4
HCGL5
HCGL6
HCGL7
HCGL8
HHRG = C2F2S3/CLINICAL = MOD, FUNCTIONAL = MOD, SERVICE = HIGH
HCGM1
HCGM2
HCGM3
HCGM4
HCGM5
HCGM6
HCGM7
HCGM8
HHRG = C2F3S0/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = MIN
HCHJ1
HCHJ2
HCHJ3
HCHJ4
HCHJ5
HCHJ6
HCHJ7
HCHJ8

1 CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE PPS TABLE

HHRG = C2F3S1/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = LOW

HCHK1
HCHK2
HCHK3
HCHK4
HCHK5
HCHK6
HCHK7
HCHK8
HHRG = C2F3S2/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = MOD
HCHL1
HCHL2
HCHL3
HCHL4
HCHL5
HCHL6
HCHL7
HCHL8
HHRG = C2F3S3/CLINICAL = MOD, FUNCTIONAL = HIGH, SERVICE = HIGH
HCHM1
HCHM2
HCHM3
HCHM4
HCHM5
HCHM6
HCHM7
HCHM8
HHRG = C2F4S0/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = MIN
HCIJ1
HCIJ2
HCIJ3
HCIJ4
HCIJ5
HCIJ6
HCIJ7
HCIJ8
HHRG = C2F4S1/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = LOW
HCIK1
HCIK2
HCIK3
HCIK4
HCIK5
HCIK6
HCIK7
HCIK8

		HHRG = C2F4S2/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = MOD
		HCIL1
		HCIL2
		HCIL3
		HCIL4
		HCIL5
		HCIL6
		HCIL7
		HCIL8
		HHRG = C2F4S3/CLINICAL = MOD, FUNCTIONAL = MAX, SERVICE = HIGH
		HCIM1
		HCIM2
		HCIM3
1	CLM_HIPPS_TB	CLAIM SNF & HHA HEALTH INSURANCE PPS TABLE
	-----	-----
		HCIM4
		HCIM5
		HCIM6
		HCIM7
		HCIM8
		HHRG = C3F0S0/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = MIN
		HDEJ1
		HDEJ2
		HDEJ3
		HDEJ4
		HDEJ5
		HDEJ6
		HDEJ7
		HDEJ8
		HHRG = C3F0S1/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = LOW
		HDEK1
		HDEK2
		HDEK3
		HDEK4
		HDEK5
		HDEK6
		HDEK7
		HDEK8
		HHRG = C3F0S2/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = MOD
		HDEL1
		HDEL2
		HDEL3
		HDEL4

HDEL5
HDEL6
HDEL7
HDEL8
HHRG = C3F0S3/CLINICAL = HIGH, FUNCTIONAL = MIN, SERVICE = HIGH
HDEM1
HDEM2
HDEM3
HDEM4
HDEM5
HDEM6
HDEM7
HDEM8
HHRG = C3F1S0/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = MIN
HDFJ1
HDFJ2
HDFJ3
HDFJ4
HDFJ5
HDFJ6
HDFJ7
HDFJ8
HHRG = C3F1S1/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = LOW
HDFK1
HDFK2
HDFK3
HDFK4
HDFK5
HDFK6
HDFK7

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CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE

PPS TABLE

HDFK8
HHRG = C3F1S2/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = MOD
HDFL1
HDFL2
HDFL3
HDFL4
HDFL5
HDFL6
HDFL7
HDFL8
HHRG = C3F1S3/CLINICAL = HIGH, FUNCTIONAL = LOW, SERVICE = HIGH

HDFM1
HDFM2
HDFM3
HDFM4
HDFM5
HDFM6
HDFM7
HDFM8
HHRG = C3F2S0/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = MIN
HDGJ1
HDGJ2
HDGJ3
HDGJ4
HDGJ5
HDGJ6
HDGJ7
HDGJ8
HHRG = C3F2S1/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = LOW
HDGK1
HDGK2
HDGK3
HDGK4
HDGK5
HDGK6
HDGK7
HDGK8
HHRG = C3F2S2/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = MOD
HDGL1
HDGL2
HDGL3
HDGL4
HDGL5
HDGL6
HDGL7
HDGL8
HHRG = C3F2S3/CLINICAL = HIGH, FUNCTIONAL = MOD, SERVICE = HIGH
HDGM1
HDGM2
HDGM3
HDGM4
HDGM5
HDGM6
HDGM7
HDGM8

1	CLM_HIPPS_TB	CLAIM SNF & HHA HEALTH INSURANCE	PPS TABLE
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		HDHJ3	
		HDHJ4	
		HDHJ5	
		HDHJ6	
		HDHJ7	
		HDHJ8	
		HHRG = C3F3S0/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = MIN	
		HDHJ1	
		HDHJ2	
		HDHJ3	
		HDHJ4	
		HDHJ5	
		HDHJ6	
		HDHJ7	
		HDHJ8	
		HHRG = C3F3S1/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = LOW	
		HDHK1	
		HDHK2	
		HDHK3	
		HDHK4	
		HDHK5	
		HDHK6	
		HDHK7	
		HDHK8	
		HHRG = C3F3S2/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = MOD	
		HDHL1	
		HDHL2	
		HDHL3	
		HDHL4	
		HDHL5	
		HDHL6	
		HDHL7	
		HDHL8	
		HHRG = C3F3S3/CLINICAL = HIGH, FUNCTIONAL = HIGH, SERVICE = HIGH	
		HDHM1	
		HDHM2	
		HDHM3	
		HDHM4	
		HDHM5	
		HDHM6	
		HDHM7	
		HDHM8	
		HHRG = C3F4S0/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = MIN	
		HDIJ1	
		HDIJ2	
		HDIJ3	
		HDIJ4	

HDIJ5
HDIJ6
HDIJ7
HDIJ8
HHRG = C3F4S1/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = LOW
HDIK1
HDIK2
HDIK3
HDIK4
HDIK5
HDIK6
HDIK7
HDIK8
HHRG = C3F4S2/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = MOD
HDIL1
HDIL2
HDIL3
HDIL4
HDIL5
HDIL6

1 CLM_HIPPS_TB

CLAIM SNF & HHA HEALTH INSURANCE PPS TABLE

HDIL7
HDIL8
HHRG = C3F4S3/CLINICAL = HIGH, FUNCTIONAL = MAX, SERVICE = HIGH
HDIM1
HDIM2
HDIM3
HDIM4
HDIM5
HDIM6
HDIM7
HDIM8

1 CLM_IP_ADMSN_TYPE_TB

CLAIM INPATIENT ADMISSION TYPE TABLE

0 = BLANK
1 = EMERGENCY - THE PATIENT REQUIRED
IMMEDIATE MEDICAL INTERVENTION AS A
RESULT OF SEVERE, LIFE THREATENING, OR
POTENTIALLY DISABLING CONDITIONS.

GENERALLY, THE PATIENT WAS ADMITTED
THROUGH THE EMERGENCY ROOM.

2 = URGENT - THE PATIENT REQUIRED IMMEDIATE
ATTENTION FOR THE CARE AND TREATMENT
OF A PHYSICAL OR MENTAL DISORDER.

GENERALLY, THE PATIENT WAS ADMITTED TO
THE FIRST AVAILABLE AND SUITABLE
ACCOMMODATION.

3 = ELECTIVE - THE PATIENT'S CONDITION
PERMITTED ADEQUATE TIME TO SCHEDULE THE
AVAILABILITY OF SUITABLE ACCOMMODATIONS.

4 = NEWBORN - NECESSITATES THE USE OF
SPECIAL SOURCE OF ADMISSION CODES.

5 THRU 8 = RESERVED.

9 = UNKNOWN - INFORMATION NOT AVAILABLE.

1 CLM_MDCR_NPMT_RSN_TB

CLAIM MEDICARE NON-PAYMENT REASON TABLE

A = COVERED WORKER'S COMPENSATION (OBSOLETE)
B = BENEFIT EXHAUSTED
C = CUSTODIAL CARE - NONCOVERED CARE
(INCLUDES ALL 'BENEFICIARY AT FAULT'
WAIVER CASES) (OBSOLETE)
E = HMO OUT-OF-PLAN SERVICES NOT EMERGENCY
OR URGENTLY NEEDED (OBSOLETE)
E = MSP COST AVOIDED - IRS/SSA/HCFA DATA
MATCH (EFF. 7/00)
F = MSP COST AVOID HMO RATE CELL (EFF. 7/00)
G = MSP COST AVOIDED LITIGATION SETTLEMENT
(EFF. 7/00)
H = MSP COST AVOIDED EMPLOYER VOLUNTARY
REPORTING (EFF. 7/00)
J = MSP COST AVOID INSURER VOLUNTARY
REPORTING (EFF. 7/00)
K = MSP COST AVOID INITIAL ENROLLMENT
QUESTIONNAIRE (EFF. 7/00)
N = ALL OTHER REASONS FOR NONPAYMENT
P = PAYMENT REQUESTED
Q = MSP COST AVOIDED VOLUNTARY AGREEMENT
(EFF. 7/00)
R = BENEFITS REFUSED, OR EVIDENCE NOT

SUBMITTED
T = MSP COST AVOIDED - IEQ CONTRACTOR
(EFF. 9/76) (OBSOLETE 6/30/00)
U = MSP COST AVOIDED - HMO RATE CELL
ADJUSTMENT (EFF. 9/76) (OBSOLETE 6/30/00)
V = MSP COST AVOIDED - LITIGATION
SETTLEMENT (EFF. 9/76) (OBSOLETE 6/30/00)
W = WORKER'S COMPENSATION (OBSOLETE)
X = MSP COST AVOIDED - GENERIC
Y = MSP COST AVOIDED - IRS/SSA DATA
MATCH PROJECT (OBSOLETE 6/30/00)
Z = ZERO REIMBURSEMENT RAPS -- ZERO REIMBURSEMENT
MADE DUE TO MEDICAL REVIEW INTERVENTION OR
WHERE PROVIDER SPECIFIC ZERO PAYMENT HAS BEEN
DETERMINED. (EFFECTIVE WITH HHPPS - 10/00)

1 CLM_OCRNC_SPAN_TB

CLAIM OCCURRENCE SPAN TABLE

70 = EFF 10/93, PAYER USE ONLY, THE
NONUTILIZATION FROM/THRU DATES
FOR PPS-INLIER STAY WHERE BENE HAD
EXHAUSTED ALL FULL/COINSURANCE DAYS, BUT
COVERED ON COST REPORT.
SNF QUALIFYING HOSPITAL STAY FROM/THRU DATES
71 = HOSPITAL PRIOR STAY DATES - THE FROM/
THRU DATES OF ANY HOSPITAL STAY THAT
ENDED WITHIN 60 DAYS OF THIS HOSPITAL
OR SNF ADMISSION.
72 = FIRST/LAST VISIT - THE DATES OF THE
FIRST AND LAST VISITS OCCURRING IN THIS
BILLING PERIOD IF THE DATES ARE DIFFERENT
FROM THOSE IN THE STATEMENT COVERS PERIOD.
73 = BENEFIT ELIGIBILITY PERIOD - THE
INCLUSIVE DATES DURING WHICH CHAMPUS
MEDICAL BENEFITS ARE AVAILABLE TO A
SPONSOR'S BENE AS SHOWN ON THE
BENE'S ID CARD.
74 = NON-COVERED LEVEL OF CARE - THE FROM/
THRU DATES OF A PERIOD AT A NONCOVERED
LEVEL OF CARE IN AN OTHERWISE
COVERED STAY, EXCLUDING ANY PERIOD
REPORTED WITH OCCURRENCE SPAN CODE 76,

77, OR 79.

75 = THE FROM/THRU DATES OF SNF LEVEL OF CARE DURING IP HOSPITAL STAY. SHOWS PRO APPROVAL OF PATIENT REMAINING IN HOSPITAL BECAUSE SNF BED NOT AVAILABLE. NOT APPLICABLE TO SWING BED CASES. PPS HOSPITALS USE IN DAY OUTLIER CASES ONLY.

76 = PATIENT LIABILITY - FROM/THRU DATES OF PERIOD OF NONCOVERED CARE FOR WHICH HOSPITAL MAY CHARGE BENE. THE FI OR PRO MUST HAVE APPROVED SUCH CHARGES IN ADVANCE. PATIENT MUST BE NOTIFIED IN WRITING 3 DAYS PRIOR TO NONCOVERED PERIOD

77 = PROVIDER LIABILITY - THE FROM/THRU DATES OF PERIOD OF NONCOVERED CARE FOR WHICH THE PROVIDER IS LIABLE. EFF 3/92, APPLIES TO PROVIDER LIABILITY WHERE BENE IS CHARGED WITH UTILIZATION AND IS LIABLE FOR DEDUCTIBLE/COINSURANCE

78 = SNF PRIOR STAY DATES - THE FROM/THRU DATES OF ANY SNF STAY THAT ENDED WITHIN 60 DAYS OF THIS HOSPITAL OR SNF ADMISSION.

79 = (PAYER CODE) - EFF 3/92, FROM/THRU DATES OF PERIOD OF NONCOVERED CARE WHERE BENE IS NOT CHARGED WITH UTILIZATION, DEDUCTIBLE, OR COINSURANCE. AND PROVIDER IS LIABLE. EFF 9/93, NONCOVERED PERIOD OF CARE DUE TO LACK OF MEDICAL NECESSITY.

1 CLM_OCRNC_SPAN_TB

CLAIM OCCURRENCE SPAN TABLE

80 - 99 = RESERVED FOR STATE ASSIGNMENT

M0 = PRO/UR APPROVED STAY DATES - EFF 10/93, THE FIRST AND LAST DAYS THAT WERE APPROVED WHERE NOT ALL OF THE STAY WAS APPROVED.

1 CLM_PPS_IND_TB

CLAIM PPS INDICATOR TABLE

EFFECTIVE NCH WEEKLY PROCESS DATE 10/3/97 - 5/29/98

0 = NOT PPS BILL (CLAIM CONTAINS NO PPS INDICATOR)

2 = PPS BILL (CLAIM CONTAINS PPS INDICATOR)

EFFECTIVE NCH WEEKLY PROCESS DATE 6/5/98

0 = NOT APPLICABLE (CLAIM CONTAINS NEITHER PPS
NOR DEEMED INSURED MQGE STATUS INDICATORS)

1 = DEEMED INSURED MQGE (CLAIM CONTAINS DEEMED
INSURED MQGE INDICATOR BUT NOT PPS INDICATOR)

2 = PPS BILL (CLAIM CONTAINS PPS INDICATOR BUT NO
DEEMED INSURED MQGE STATUS INDICATOR)

3 = BOTH PPS AND DEEMED INSURED MQGE (CONTAINS BOTH
PPS AND DEEMED INSURED MQGE INDICATORS)

1 CLM_RLT_COND_TB

CLAIM RELATED CONDITION TABLE

- 01 = MILITARY SERVICE RELATED - MEDICAL
CONDITION INCURRED DURING MILITARY
SERVICE.
- 02 = EMPLOYMENT RELATED - PATIENT ALLEGED
THAT THE MEDICAL CONDITION CAUSING THIS
EPISODE OF CARE WAS DUE TO ENVIRONMENT/
EVENTS RESULTING FROM EMPLOYMENT.
- 03 = PATIENT COVERED BY INSURANCE NOT
REFLECTED HERE - INDICATES THAT PATIENT
OR PATIENT REPRESENTATIVE HAS STATED
THAT COVERAGE MAY EXIST BEYOND THAT
REFLECTED ON THIS BILL.
- 04 = HEALTH MAINTENANCE ORGANIZATION (HMO)
ENROLLEE - MEDICARE BENEFICIARY IS
ENROLLED IN AN HMO. EFF 9/93, HOSPITAL
MUST ALSO EXPECT TO RECEIVE PAYMENT
FROM HMO.
- 05 = LIEN HAS BEEN FILED - PROVIDER HAS
FILED LEGAL CLAIM FOR RECOVERY OF FUNDS
POTENTIALLY DUE A PATIENT AS A RESULT
OF LEGAL ACTION INITIATED BY OR ON
BEHALF OF THE PATIENT.

- 06 = ESRD PATIENT IN 1ST 18 MONTHS OF ENTITLEMENT COVERED BY EMPLOYER GROUP HEALTH INSURANCE - INDICATES MEDICARE MAY BE SECONDARY INSURER. EFF 3/1/96, ESRD PATIENT IN 1ST 30 MONTHS OF ENTITLEMENT COVERED BY EMPLOYER GROUP HEALTH INSURANCE.
- 07 = TREATMENT OF NONTERMINAL CONDITION FOR HOSPICE PATIENT - THE PATIENT IS A HOSPICE ENROLLEE, BUT THE PROVIDER IS NOT TREATING A TERMINAL CONDITION AND IS REQUESTING MEDICARE REIMBURSEMENT.
- 08 = BENEFICIARY WOULD NOT PROVIDE INFORMATION CONCERNING OTHER INSURANCE COVERAGE.
- 09 = NEITHER PATIENT NOR SPOUSE IS EMPLOYED - CODE INDICATES THAT IN RESPONSE TO DEVELOPMENT QUESTIONS, THE PATIENT AND SPOUSE HAVE DENIED EMPLOYMENT.
- 10 = PATIENT AND/OR SPOUSE IS EMPLOYED BUT NO EGHP COVERAGE EXISTS OR (EFF 9/93) OTHER EMPLOYER SPONSORED/PROVIDED HEALTH INSURANCE COVERING PATIENT.
- 11 = THE DISABLED BENEFICIARY AND/OR FAMILY MEMBER HAS NO GROUP COVERAGE FROM A LGHP OR (EFF 9/93) OTHER EMPLOYER SPONSORED/PROVIDED HEALTH INSURANCE COVERING PATIENT.
- 12 = PAYER CODE - RESERVED FOR INTERNAL USE ONLY BY THIRD PARTY PAYERS. HCFA WILL ASSIGN AS NEEDED. PROVIDERS WILL NOT REPORT THEM.
- 13 = PAYER CODE - RESERVED FOR INTERNAL USE ONLY BY THIRD PARTY PAYERS. HCFA WILL ASSIGN AS NEEDED. PROVIDERS WILL NOT REPORT THEM.
- 14 = PAYER CODE - RESERVED FOR INTERNAL CLAIM RELATED CONDITION TABLE

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USE ONLY BY THIRD PARTY PAYERS. HCFA
WILL ASSIGN AS NEEDED. PROVIDERS WILL
NOT REPORT THEM.

- 15 = CLEAN CLAIM (EFF 10/92)
- 16 = SNF TRANSITION EXEMPTION - AN
EXEMPTION FROM THE POST-HOSPITAL

- REQUIREMENT APPLIES FOR THIS SNF STAY
OR THE QUALIFYING STAY DATES ARE MORE
THAN 30 DAYS PRIOR TO THE ADMISSION DATE
- 17 = PATIENT IS OVER 100 YEARS OLD - CODE
INDICATES THAT THE PATIENT WAS OVER
100 YEARS OLD AT THE DATE OF ADMISSION.
- 18 = MAIDEN NAME RETAINED - A DEPENDENT
SPOUSE ENTITLED TO BENEFITS WHO DOES
NOT USE HER HUSBAND'S LAST NAME.
- 19 = CHILD RETAINS MOTHER'S NAME - A
PATIENT WHO IS A DEPENDENT CHILD
ENTITLED TO CHAMPVA BENEFITS THAT DOES
NOT HAVE FATHER'S LAST NAME.
- 20 = BENE REQUESTED BILLING - PROVIDER
REALIZES THE SERVICES ON THIS BILL ARE AT A
NONCOVERED LEVEL OF CARE OR OTHERWISE EXCLUDED
FROM COVERAGE, BUT THE BENE HAS REQUESTED
FORMAL DETERMINATION
- 21 = BILLING FOR DENIAL NOTICE - THE SNF OR HHA
REALIZES SERVICES ARE AT A NONCOVERED LEVEL OF
CARE OR EXCLUDED, BUT REQUESTS A MEDICARE DENIAL
IN ORDER TO BILL MEDICAID OR OTHER INSURER
- 22 = PATIENT ON MULTIPLE DRUG REGIMEN - A
PATIENT WHO IS RECEIVING MULTIPLE
INTRAVENOUS DRUGS WHILE ON HOME IV
THERAPY
- 23 = HOMECAREGIVER AVAILABLE - THE PATIENT
HAS A CAREGIVER AVAILABLE TO ASSIST HIM
OR HER DURING SELF-ADMINISTRATION OF AN
INTRAVENOUS DRUG
- 24 = HOME IV PATIENT ALSO RECEIVING HHA
SERVICES - THE PATIENT IS UNDER CARE
OF HHA WHILE RECEIVING HOME IV DRUG
THERAPY SERVICES
- 25 = RESERVED FOR NATIONAL ASSIGNMENT
- 26 = VA ELIGIBLE PATIENT CHOOSES TO
RECEIVE SERVICES IN MEDICARE CERTIFIED
FACILITY RATHER THAN A VA FACILITY
(EFF 3/92)
- 27 = PATIENT REFERRED TO A SOLE COMMUNITY
HOSPITAL FOR A DIAGNOSTIC LABORATORY
TEST - (SOLE COMMUNITY HOSPITAL ONLY) .
(EFF 9/93)
- 28 = PATIENT AND/OR SPOUSE'S EGHP IS

SECONDARY TO MEDICARE -
QUALIFYING EGHP FOR EMPLOYERS WHO HAVE
FEWER THAN 20 EMPLOYEES. (EFF 9/93)
29 = DISABLED BENEFICIARY AND/OR FAMILY
MEMBER'S LGHP IS SECONDARY TO
MEDICARE - QUALIFYING LGHP FOR
EMPLOYER HAVING FEWER THAN 100 FULL AND
PART-TIME EMPLOYEES

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CLAIM RELATED CONDITION TABLE

31 = PATIENT IS STUDENT (FULL TIME - DAY) -
PATIENT DECLARES THAT HE OR SHE IS
ENROLLED AS A FULL TIME DAY STUDENT.
32 = PATIENT IS STUDENT (COOPERATIVE/WORK
STUDY PROGRAM)
33 = PATIENT IS STUDENT (FULL TIME - NIGHT)
- PATIENT DECLARES THAT HE OR SHE IS
ENROLLED AS A FULL TIME NIGHT STUDENT.
34 = PATIENT IS STUDENT (PART TIME) -
PATIENT DECLARES THAT HE OR SHE IS
ENROLLED AS A PART TIME STUDENT.
36 = GENERAL CARE PATIENT IN A SPECIAL
UNIT - PATIENT IS TEMPORARILY PLACED IN
SPECIAL CARE UNIT BED BECAUSE NO
GENERAL CARE BEDS WERE AVAILABLE.
37 = WARD ACCOMMODATION IS PATIENT'S
REQUEST - PATIENT IS ASSIGNED TO WARD
ACCOMMODATIONS AT PATIENT'S REQUEST.
38 = SEMI-PRIVATE ROOM NOT AVAILABLE -
INDICATES THAT EITHER PRIVATE OR WARD
ACCOMMODATIONS WERE ASSIGNED BECAUSE
SEMI-PRIVATE ACCOMODATIONS WERE NOT
AVAILABLE.
39 = PRIVATE ROOM MEDICALLY NECESSARY -
PATIENT NEEDED A PRIVATE ROOM FOR
MEDICAL REASONS.
40 = SAME DAY TRANSFER - PATIENT
TRANSFERRED TO ANOTHER FACILITY
BEFORE MIDNIGHT OF THE DAY OF ADMISSION.
41 = PARTIAL HOSPITALIZATION - EFF 3/92,
INDICATES CLAIM IS FOR PARTIAL
HOSPITALIZATION SERVICES. FOR OP
SERVICES, THIS INCLUDES A VARIETY

OF PSYCH PROGRAMS.
42 = RESERVED FOR NATIONAL ASSIGNMENT.
43 = RESERVED FOR NATIONAL ASSIGNMENT.
44 = RESERVED FOR NATIONAL ASSIGNMENT.
45 = RESERVED FOR NATIONAL ASSIGNMENT.
46 = NONAVAILABILITY STATEMENT ON FILE FOR
CHAMPUS CLAIM FOR NONEMERGENCY IP CARE
FOR CHAMPUS BENE RESIDING WITHIN THE
CATCHMENT AREA (USUALLY A 40 MILE
RADIUS) OF A UNIFORM SERVICES HOSPITAL.
47 = RESERVED FOR CHAMPUS.
48 = RESERVED FOR NATIONAL ASSIGNMENT.
49 = RESERVED FOR NATIONAL ASSIGNMENT.
50 = RESERVED FOR NATIONAL ASSIGNMENT.
51 = RESERVED FOR NATIONAL ASSIGNMENT.
52 = RESERVED FOR NATIONAL ASSIGNMENT.
53 = RESERVED FOR NATIONAL ASSIGNMENT.
54 = RESERVED FOR NATIONAL ASSIGNMENT.
55 = SNF BED NOT AVAILABLE - THE PATIENT'S
SNF ADMISSION WAS DELAYED MORE THAN 30
DAYS AFTER HOSPITAL DISCHARGE BECAUSE
A SNF BED WAS NOT AVAILABLE.
56 = MEDICAL APPROPRIATENESS - PATIENT'S
SNF ADMISSION WAS DELAYED MORE THAN 30
DAYS AFTER HOSPITAL DISCHARGE BECAUSE

CLAIM RELATED CONDITION TABLE

PHYSICAL CONDITION MADE IT INAPPROPRIATE
TO BEGIN ACTIVE CARE WITHIN THAT PERIOD
57 = SNF READMISSION - PATIENT PREVIOUSLY
RECEIVED MEDICARE COVERED SNF CARE
WITHIN 30 DAYS OF THE CURRENT SNF
ADMISSION.
58 = PAYMENT OF SNF CLAIMS FOR BENEFICIARIES
DISENROLLING FROM TERMINATING M+C PLANS
PLANS WHO HAVE NOT MET THE 3-DAY HOSPITAL
STAY REQUIREMENT (EFF. 10/1/00)
59 = RESERVED FOR NATIONAL ASSIGNMENT.
60 = OPERATING COST DAY OUTLIER - PRICER
INDICATES THIS BILL IS LENGTH OF STAY
OUTLIER (PPS)
61 = OPERATING COST COST OUTLIER - PRICER
INDICATES THIS BILL IS A COST OUTLIER

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(PPS)

62 = PIP BILL - THIS BILL IS A PERIODIC
INTERIM PAYMENT BILL.

63 = PRO DENIAL RECEIVED BEFORE BATCH
CLEARANCE REPORT - THE HCSSACL RECEIPT DATE
IS USED ON PRO ADJUSTMENT IF THE PRO'S
NOTIFICATION IS BEFORE ORIG BILL'S ACCEPTANCE
REPORT. (PAYER ONLY CODE EFF 9/93)

64 = OTHER THAN CLEAN CLAIM - THE CLAIM IS
NOT A 'CLEAN CLAIM'

65 = NON-PPS CODE - THE BILL IS NOT A
PROSPECTIVE PAYMENT SYSTEM BILL.

66 = OUTLIER NOT CLAIMED - BILL MAY MEET
THE CRITERIA FOR COST OUTLIER, BUT THE
HOSPITAL DID NOT CLAIM THE COST OUTLIER
(PPS)

67 = BENEFICIARY ELECTS NOT TO USE LTR DAYS

68 = BENEFICIARY ELECTS TO USE LTR DAYS

69 = OPERATING IME PAYMENT ONLY - PROVIDERS
REQUEST FOR IME PAYMENT FOR EACH DISCHARGE
OF MCO ENROLLEE, BEGINNING 1/1/98, FROM
TEACHING HOSPITALS (FACILITIES WITH APPROVED
MEDICAL RESIDENCY TRAINING PROGRAM); NOT
STORED IN NCH. EXCEPTION: PROBLEM IN
STARTUP YEAR MAY HAVE RESULTED IN THIS
SPECIAL IME PAYMENT REQUEST BEING ERRONEOUSLY
STORED IN NCH. IF PRESENT, DISREGARD CLAIM
AS CONDITION CODE '69' IS NOT VALID NCH
CLAIM.

70 = SELF-ADMINISTERED EPO - BILLING IS
FOR A HOME DIALYSIS PATIENT WHO SELF
ADMINISTERS EPO.

71 = FULL CARE IN UNIT - BILLING IS FOR A
PATIENT WHO RECEIVED STAFF ASSISTED
DIALYSIS SERVICES IN A HOSPITAL OR
RENAL DIALYSIS FACILITY.

72 = SELF CARE IN UNIT - BILLING IS FOR A
PATIENT WHO MANAGED HIS OWN DIALYSIS
SERVICES WITHOUT STAFF ASSISTANCE IN A
HOSPITAL OR RENAL DIALYSIS FACILITY.

73 = SELF CARE TRAINING - BILLING IS FOR
SPECIAL DIALYSIS SERVICES WHERE THE

CLAIM RELATED CONDITION TABLE

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PATIENT AND HELPER (IF NECESSARY) WERE
LEARNING TO PERFORM DIALYSIS.

74 = HOME - BILLING IS FOR A PATIENT WHO
RECEIVED DIALYSIS SERVICES AT HOME.

75 = HOME 100% REIMBURSEMENT -
(NOT TO BE USED FOR SERVICES AFTER 4/15/90)
THE BILLING IS FOR HOME DIALYSIS PATIENT USING
A DIALYSIS MACHINE THAT WAS PURCHASED
UNDER THE 100% PROGRAM.

76 = BACK-UP FACILITY - BILLING IS FOR A
PATIENT WHO RECEIVED DIALYSIS SERVICES
IN A BACK-UP FACILITY.

77 = PROVIDER ACCEPTS OR IS OBLIGATED/
REQUIRED DUE TO CONTRACTUAL AGREEMENT
OR LAW TO ACCEPT PAYMENT BY A PRIMARY
PAYER AS PAYMENT IN FULL - MEDICARE
PAYS NOTHING.

78 = NEW COVERAGE NOT IMPLEMENTED BY HMO -
EFF 3/92, INDICATES NEWLY COVERED
SERVICE UNDER MEDICARE FOR WHICH HMO
DOES NOT PAY.

79 = CORF SERVICES PROVIDED OFF SITE -
CODE INDICATES THAT PHYSICAL THERAPY,
OCCUPATIONAL THERAPY, OR SPEECH PATH-
OLOGY SERVICES WERE PROVIDED OFF SITE.

80 - 99 = RESERVED FOR STATE ASSIGNMENT.

A0 = CHAMPUS EXTERNAL PARTNERSHIP PROGRAM
SPECIAL PROGRAM INDICATOR CODE. (EFF 10/93)

A1 = EPSDT/CHAP - EARLY AND PERIODIC
SCREENING DIAGNOSIS AND TREATMENT
SPECIAL PROGRAM INDICATOR CODE. (EFF 10/93)

A2 = PHYSICALLY HANDICAPPED CHILDREN'S
PROGRAM - SERVICES PROVIDED RECEIVE
SPECIAL FUNDING THROUGH TITLE 8 OF
THE SOCIAL SECURITY ACT OR THE CHAMPUS
PROGRAM FOR THE HANDICAPPED. (EFF 10/93)

A3 = SPECIAL FEDERAL FUNDING - DESIGNED FOR
UNIFORM USE BY STATE UNIFORM BILLING
COMMITTEES.
SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)

A4 = FAMILY PLANNING - DESIGNED FOR
UNIFORM USE BY STATE UNIFORM BILLING
COMMITTEES.

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 SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
A5 = DISABILITY - DESIGNED FOR UNIFORM
 USE BY STATE UNIFORM BILLING
 COMMITTEES.
 SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
A6 = PPV/MEDICARE - IDENTIFIES THAT
 PNEUMOCOCCAL PNEUMONIA 100% PAYMENT
 VACCINE (PPV) SERVICES SHOULD BE
 REIMBURSED UNDER A SPECIAL MEDICARE
 PROGRAM PROVISION.
 SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
A7 = INDUCED ABORTION TO AVOID DANGER TO
 WOMAN'S LIFE.
 SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
A8 = INDUCED ABORTION - VICTIM OF RAPE/
 CLAIM RELATED CONDITION TABLE

 INCEST.
 SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
A9 = SECOND OPINION SURGERY - SERVICES
 REQUESTED TO SUPPORT SECOND OPINION
 ON SURGERY. PART B DEDUCTIBLE AND
 COINSURANCE DO NOT APPLY.
 SPECIAL PROGRAM INDICATOR CODE (EFF 10/93)
B0 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B1 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B2 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B3 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B4 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B5 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B6 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B7 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B8 = SPECIAL PROGRAM INDICATOR
 RESERVED FOR NATIONAL ASSIGNMENT.
B9 = SPECIAL PROGRAM INDICATOR

RESERVED FOR NATIONAL ASSIGNMENT.
C0 = RESERVED FOR NATIONAL ASSIGNMENT.
C1 = APPROVED AS BILLED - THE SERVICES
PROVIDED FOR THIS BILLING PERIOD HAVE
BEEN REVIEWED BY THE PRO/UR OR
INTERMEDIARY AND ARE FULLY APPROVED
INCLUDING ANY DAY OR COST OUTLIER. (EFF 10/93)
C2 = AUTOMATIC APPROVAL AS BILLED BASED ON
FOCUSED REVIEW. (NO LONGER USED FOR
MEDICARE)
PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
C3 = PARTIAL APPROVAL - THE SERVICES
PROVIDED FOR THIS BILLING PERIOD HAVE
BEEN REVIEWED BY THE PRO/UR OR
INTERMEDIARY AND SOME PORTION HAS BEEN
DENIED (DAYS OR SERVICES). (EFF 10/93)
C4 = ADMISSION/SERVICES DENIED - INDICATES
THAT ALL OF THE SERVICES WERE DENIED
BY THE PRO/UR.
PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
C5 = POSTPAYMENT REVIEW APPLICABLE - PRO/UR
REVIEW TO TAKE PLACE AFTER PAYMENT.
PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
C6 = ADMISSION PREAUTHORIZATION - THE
PRO/UR AUTHORIZED THIS ADMISSION/
SERVICE BUT HAS NOT REVIEWED THE
SERVICES PROVIDED.
PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
C7 = EXTENDED AUTHORIZATION - THE PRO HAS
AUTHORIZED THESE SERVICES FOR AN
EXTENDED LENGTH OF TIME BUT HAS NOT
REVIEWED THE SERVICES PROVIDED.

CLAIM RELATED CONDITION TABLE

PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
C8 = RESERVED FOR NATIONAL ASSIGNMENT.
PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
C9 = RESERVED FOR NATIONAL ASSIGNMENT.
PRO APPROVAL INDICATOR SERVICES (EFF 10/93)
D0 = CHANGES TO SERVICE DATES.
CHANGE CONDITION (EFF 10/93)
D1 = CHANGES IN CHARGES.
CHANGE CONDITION (EFF 10/93)

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D2 = CHANGES IN REVENUE CODES/HCPCS.
CHANGE CONDITION (EFF 10/93)

D3 = SECOND OR SUBSEQUENT INTERIM
PPS BILL.
CHANGE CONDITION (EFF 10/93)

D4 = CHANGE IN GROUPER INPUT (DIAGNOSIS
AND/OR PROCEDURES ARE CHANGED RESULTING
IN A DIFFERENT DRG).
CHANGE CONDITION (EFF 10/93)

D5 = CANCEL ONLY TO CORRECT A BENEFICIARY
CLAIM ACCOUNT NUMBER OR PROVIDER
IDENTIFICATION NUMBER.
CHANGE CONDITION (EFF 10/93)

D6 = CANCEL ONLY TO REPAY A DUPLICATE
PAYMENT OR OIG OVERPAYMENT (INCLUDES
CANCELLATION OF AN OP BILL CONTAINING
SERVICES REQUIRED TO BE INCLUDED ON THE
IP BILL). CHANGE CONDITION EFF 10/93.

D7 = CHANGE TO MAKE MEDICARE THE SECONDARY
PAYER.
CHANGE CONDITION (EFF 10/93)

D8 = CHANGE TO MAKE MEDICARE THE PRIMARY
PAYER.
CHANGE CONDITION (EFF 10/93)

D9 = ANY OTHER CHANGE.
CHANGE CONDITION (EFF 10/93)

E0 = CHANGE IN PATIENT STATUS.
CHANGE CONDITION (EFF 10/93)

EY = NATIONAL EMPHYSEMA TREATMENT TRIAL (NETT)
OR LUNG VOLUME REDUCTION SURGERY (LVRS)
CLINICAL STUDY (EFF. 11/97)

G0 = MULTIPLE MEDICAL VISITS OCCUR ON THE SAME
DAY IN THE SAME REVENUE CENTER BUT VISITS
ARE DISTINCT AND CONSTITUTE INDEPENDENT
VISITS (ALLOWS FOR PAYMENT UNDER OUTPATIENT
PPS -- EFF. 7/3/00).

M0 = ALL INCLUSIVE RATE FOR OUTPATIENT SERVICES.
(PAYER ONLY CODE)

M1 = ROSTER BILLED INFLUENZA VIRUS VACCINE.
(PAYER ONLY CODE)
EFF 10/96, ALSO INCLUDES PNEUMOCOCCAL
PNEUMONIA VACCINE (PPV)

M2 = HH OVERRIDE CODE - HOME HEALTH TOTAL
REIMBURSEMENT EXCEEDS THE \$150,000 CAP

OR THE NUMBER OF TOTAL VISITS EXCEEDS THE
150 LIMITATION. (EFF 4/3/95)
(PAYER ONLY CODE)

W0 = UNITED MINE WORKERS OF AMERICA (UMWA)
SNF DEMONSTRATION INDICATOR (EFF 1/97);
CLAIM RELATED CONDITION TABLE

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BUT NO CLAIMS TRANSMITTED UNTIL 2/98)

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- 01 = AUTO ACCIDENT - THE DATE OF AN AUTO
ACCIDENT.
- 02 = NO-FAULT INSURANCE INVOLVED, INCLUDING
AUTO ACCIDENT/OTHER - THE DATE OF AN
ACCIDENT WHERE THE STATE HAS APPLICABLE
NO-FAULT LIABILITY LAWS, (I.E., LEGAL
BASIS FOR SETTLEMENT WITHOUT ADMISSION
OR PROOF OF GUILT).
- 03 = ACCIDENT/TORT LIABILITY - THE DATE OF
AN ACCIDENT RESULTING FROM A THIRD
PARTY'S ACTION THAT MAY INVOLVE A CIVIL
COURT PROCESS IN AN ATTEMPT TO REQUIRE
PAYMENT BY THE THIRD PARTY, OTHER THAN
NO-FAULT LIABILITY.
- 04 = ACCIDENT/EMPLOYMENT RELATED - THE
DATE OF AN ACCIDENT RELATING TO THE
PATIENT'S EMPLOYMENT.
- 05 = OTHER ACCIDENT - THE DATE OF AN ACCIDENT
NOT DESCRIBED BY THE CODES 01 THRU 04.
- 06 = CRIME VICTIM - CODE INDICATING THE
DATE ON WHICH A MEDICAL CONDITION
RESULTED FROM ALLEGED CRIMINAL ACTION
COMMITTED BY ONE OR MORE PARTIES.
- 07 = RESERVED FOR NATIONAL ASSIGNMENT.
- 08 = RESERVED FOR NATIONAL ASSIGNMENT.
- 11 = ONSET OF SYMPTOMS/ILLNESS - THE DATE
THE PATIENT FIRST BECAME AWARE OF
SYMPTOMS/ILLNESS.
- 12 = DATE OF ONSET FOR A CHRONICALLY
DEPENDENT INDIVIDUAL - CODE INDICATES

THE DATE THE PATIENT/BENE BECAME
A CHRONICALLY DEPENDENT INDIVIDUAL.

13 = RESERVED FOR NATIONAL ASSIGNMENT.

14 = RESERVED FOR NATIONAL ASSIGNMENT.

15 = RESERVED FOR NATIONAL ASSIGNMENT.

16 = RESERVED FOR NATIONAL ASSIGNMENT.

17 = DATE OUTPATIENT OCCUPATIONAL THERAPY
PLAN ESTABLISHED OR LAST REVIEWED -
CODE INDICATING THE DATE AN OCCUPATIONAL
THERAPY PLAN WAS ESTABLISHED OR
LAST REVIEWED (EFF 3/93)

18 = DATE OF RETIREMENT (PATIENT/BENE)
- CODE INDICATES THE DATE OF RETIREMENT
FOR THE PATIENT/BENE.

19 = DATE OF RETIREMENT SPOUSE -
CODE INDICATES THE DATE OF RETIREMENT
FOR THE PATIENT'S SPOUSE.

20 = GUARANTEE OF PAYMENT BEGAN - THE DATE
ON WHICH THE PROVIDER BEGAN CLAIMING
MEDICARE PAYMENT UNDER THE GUARANTEE
OF PAYMENT PROVISION.

21 = UR NOTICE RECEIVED - CODE INDICATING
THE DATE OF RECEIPT BY THE HOSPITAL
OF THE UR COMMITTEE'S FINDING THAT THE
ADMISSION OR FUTURE STAY WAS NOT
MEDICALLY NECESSARY.

22 = ACTIVE CARE ENDED - THE DATE ON WHICH
CLAIM RELATED OCCURRENCE TABLE

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A COVERED LEVEL OF CARE ENDED IN A SNF
OR GENERAL HOSPITAL, OR DATE ACTIVE CARE
ENDED IN A PSYCHIATRIC OR TUBERCULOSIS
HOSPITAL. (FOR USE BY INTERMEDIARY ONLY)

23 = RESERVED FOR NATIONAL ASSIGNMENT
(EFF 10/93).

BENEFITS EXHAUSTED - THE LAST DATE
FOR WHICH BENEFITS CAN BE PAID.
(TERM 9/30/93; REPLACED BY CODE A3)

24 = DATE INSURANCE DENIED - THE DATE THE
INSURER'S DENIAL OF COVERAGE WAS
RECEIVED BY A HIGHER PRIORITY PAYER.

25 = DATE BENEFITS TERMINATED BY PRIMARY
PAYER - THE DATE ON WHICH COVERAGE

- (INCLUDING WORKER'S COMPENSATION BENEFITS OR NO-FAULT COVERAGE) IS NO LONGER AVAILABLE TO THE PATIENT.
- 26 = DATE SKILLED NURSING FACILITY (SNF) BED AVAILABLE - THE DATE ON WHICH A SNF BED BECAME AVAILABLE TO A HOSPITAL INPATIENT WHO REQUIRED ONLY SNF LEVEL OF CARE.
- 27 = DATE HOME HEALTH PLAN ESTABLISHED OR LAST REVIEWED - CODE INDICATING THE DATE A HOME HEALTH PLAN OF TREATMENT WAS ESTABLISHED OR LAST REVIEWED. NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
- 28 = DATE COMPREHENSIVE OUTPATIENT REHABILITATION PLAN ESTABLISHED OR LAST REVIEWED - CODE INDICATING THE DATE A COMPREHENSIVE OUTPATIENT REHABILITATION PLAN WAS ESTABLISHED OR LAST REVIEWED. NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
- 29 = DATE OPT PLAN ESTABLISHED OR LAST REVIEWED - THE DATE A PLAN OF TREATMENT WAS ESTABLISHED FOR OUTPATIENT PHYSICAL THERAPY. NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
- 30 = DATE SPEECH PATHOLOGY PLAN TREATMENT ESTABLISHED OR LAST REVIEWED - THE DATE A SPEECH PATHOLOGY PLAN OF TREATMENT WAS ESTABLISHED OR LAST REVIEWED. NOT USED BY HOSPITAL UNLESS OWNER OF FACILITY
- 31 = DATE BENE NOTIFIED OF INTENT TO BILL (ACCOMMODATIONS) - THE DATE OF THE NOTICE PROVIDED TO THE PATIENT BY THE HOSPITAL STATING THAT HE NO LONGER REQUIRED A COVERED LEVEL OF IP CARE.
- 32 = DATE BENE NOTIFIED OF INTENT TO BILL (PROCEDURES OR TREATMENT) - THE DATE OF THE NOTICE PROVIDED TO THE PATIENT BY THE HOSPITAL STATING REQUESTED CARE (DIAGNOSTIC PROCEDURES OR TREATMENTS) IS NOT CONSIDERED REASONABLE OR NECESSARY.
- 33 = FIRST DAY OF THE MEDICARE COORDINATION PERIOD FOR ESRD BENE - DURING WHICH MEDICARE BENEFITS ARE SECONDARY TO BENEFITS PAYABLE UNDER AN EGHP.

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CLAIM RELATED OCCURRENCE TABLE

- REQUIRED ONLY FOR ESRD BENEFICIARIES.
- 34 = DATE OF ELECTION OF EXTENDED CARE FACILITIES - THE DATE THE GUEST ELECTED TO RECEIVE EXTENDED CARE SERVICES (USED BY CHRISTIAN SCIENCE SANATORIA ONLY).
- 35 = DATE TREATMENT STARTED FOR PHYSICAL THERAPY - CODE INDICATES THE DATE SERVICES WERE INITIATED BY THE BILLING PROVIDER FOR PHYSICAL THERAPY.
- 36 = DATE OF DISCHARGE FOR THE IP HOSPITAL STAY WHEN PATIENT RECEIVED A TRANSPLANT PROCEDURE - HOSPITAL IS BILLING FOR IMMUNOSUPPRESSIVE DRUGS.
- 37 = THE DATE OF DISCHARGE FOR THE IP HOSPITAL STAY WHEN PATIENT RECEIVED A NONCOVERED TRANSPLANT PROCEDURE - HOSPITAL IS BILLING FOR IMMUNOSUPPRESSIVE DRUGS.
- 38 = DATE TREATMENT STARTED FOR HOME IV THERAPY - DATE THE PATIENT WAS FIRST TREATED IN HIS HOME FOR IV THERAPY.
- 39 = DATE DISCHARGED ON A CONTINUOUS COURSE OF IV THERAPY - DATE THE PATIENT WAS DISCHARGED FROM THE HOSPITAL ON A CONTINUOUS COURSE OF IV THERAPY.
- 40 = SCHEDULED DATE OF ADMISSION - THE DATE ON WHICH A PATIENT WILL BE ADMITTED AS AN INPATIENT TO THE HOSPITAL. (THIS CODE MAY ONLY BE USED ON AN OUTPATIENT CLAIM.)
- 41 = THE DATE ON WHICH THE FIRST OUTPATIENT DIAGNOSTIC TEST WAS PERFORMED AS PART OF A PRE-ADMISSION TESTING (PAT) PROGRAM. THIS CODE MAY ONLY BE USED IF A DATE OF ADMISSION WAS SCHEDULED PRIOR TO THE ADMINISTRATION OF THE TEST(S).
- 42 = DATE OF DISCHARGE/TERMINATION OF HOSPICE CARE - FOR THE FINAL BILL FOR HOSPICE CARE. EFF 5/93, DEFINITION REVISED TO

APPLY ONLY TO DATE PATIENT REVOKED
HOSPICE ELECTION.

- 43 = RESERVED FOR NATIONAL ASSIGNMENT.
44 = DATE TREATMENT STARTED FOR OCCUPATIONAL
THERAPY - CODE INDICATES THE DATE
SERVICES WERE INITIATED BY THE BILLING
PROVIDER FOR OCCUPATIONAL THERAPY.
45 = DATE TREATMENT STARTED FOR SPEECH
THERAPY - CODE INDICATES THE DATE
SERVICES WERE INITIATED BY THE BILLING
PROVIDER FOR SPEECH THERAPY.
46 = DATE TREATMENT STARTED FOR CARDIAC
REHABILITATION - CODE INDICATES THE
DATE SERVICES WERE INITIATED BY THE
BILLING PROVIDER FOR CARDIAC
REHABILITATION.
47 = NONCOVERED OUTLIER STAY BEGAN- CODE
CLAIM RELATED OCCURRENCE TABLE

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INDICATES THE DATE THAT COST OUTLIER
STATUS BEGAN AND NO MEDICARE PAYMENT
WILL BE MADE BECAUSE ALL BENEFITS HAVE
BEEN EXHAUSTED DURING THE INLIER STAY OR
THE BENEFICIARY DOES NOT ELECT TO USE LIFE
TIME RESERVE DAYS (TO BE IMPLEMENTED IN
1999).

- 48 = PAYER CODE - CODE RESERVED FOR
INTERNAL USE ONLY BY THIRD PARTY
PAYERS. HCFA ASSIGNS AS NEEDED FOR
YOUR USE. PROVIDERS WILL NOT REPORT IT.
49 = PAYER CODE - CODE RESERVED FOR
INTERNAL USE ONLY BY THIRD PARTY
PAYERS. HCFA ASSIGNS AS NEEDED FOR
YOUR USE. PROVIDERS WILL NOT REPORT IT.
50 - 69 = RESERVED FOR STATE ASSIGNMENT
A1 = BIRTHDATE, INSURED A - THE BIRTHDATE OF
THE INDIVIDUAL IN WHOSE NAME THE INSURANCE
IS CARRIED. (EFF 10/93)
A2 = EFFECTIVE DATE, INSURED A POLICY - A
CODE INDICATING THE FIRST DATE INSURANCE
IS IN FORCE. (EFF 10/93)
A3 = BENEFITS EXHAUSTED - CODE INDICATING
THE LAST DATE FOR WHICH BENEFITS ARE

AVAILABLE AND AFTER WHICH NO PAYMENT
CAN BE MADE TO PAYER A. (EFF 10/93)
B1 = BIRTHDATE, INSURED B - THE BIRTHDATE OF
THE INDIVIDUAL IN WHOSE NAME THE INSURANCE
IS CARRIED. (EFF 10/93)
B2 = EFFECTIVE DATE, INSURED B POLICY - A
CODE INDICATING THE FIRST DATE INSURANCE
IS IN FORCE. (EFF 10/93)
B3 = BENEFITS EXHAUSTED - CODE INDICATING
THE LAST DATE FOR WHICH BENEFITS ARE
AVAILABLE AND AFTER WHICH NO PAYMENT
CAN BE MADE TO PAYER B. (EFF 10/93)
C1 = BIRTHDATE, INSURED C - THE BIRTHDATE OF
THE INDIVIDUAL IN WHOSE NAME THE INSURANCE
IS CARRIED. (EFF 10/93)
C2 = EFFECTIVE DATE, INSURED C POLICY - A
CODE INDICATING THE FIRST DATE INSURANCE
IS IN FORCE. (EFF 10/93)
C3 = BENEFITS EXHAUSTED - CODE INDICATING
THE LAST DATE FOR WHICH BENEFITS ARE
AVAILABLE AND AFTER WHICH NO PAYMENT
CAN BE MADE TO PAYER C. (EFF 10/93)

1 CLM_SRC_IP_ADMSN_TB

CLAIM SOURCE OF INPATIENT ADMISSION TABLE

FOR INPATIENT/SNF CLAIMS:

0 = ANOMALY: INVALID VALUE, IF PRESENT,
TRANSLATE TO '9'
1 = PHYSICIAN REFERRAL - THE PATIENT WAS
ADMITTED UPON THE RECOMMENDATION OF
A PERSONAL PHYSICIAN.
2 = CLINIC REFERRAL - THE PATIENT WAS
ADMITTED UPON THE RECOMMENDATION OF
THIS FACILITY'S CLINIC PHYSICIAN.
3 = HMO REFERRAL - THE PATIENT WAS ADMITTED
UPON THE RECOMMENDATION OF AN HEALTH
MAINTENANCE ORGANIZATION (HMO)
PHYSICIAN.
4 = TRANSFER FROM HOSPITAL - THE PATIENT
WAS ADMITTED AS AN INPATIENT TRANSFER

- FROM AN ACUTE CARE FACILITY.
- 5 = TRANSFER FROM A SKILLED NURSING FACILITY (SNF) - THE PATIENT WAS ADMITTED AS AN INPATIENT TRANSFER FROM A SNF.
- 6 = TRANSFER FROM ANOTHER HEALTH CARE FACILITY - THE PATIENT WAS ADMITTED AS A TRANSFER FROM A HEALTH CARE FACILITY OTHER THAN AN ACUTE CARE FACILITY OR SNF.
- 7 = EMERGENCY ROOM - THE PATIENT WAS ADMITTED UPON THE RECOMMENDATION OF THIS FACILITY'S EMERGENCY ROOM PHYSICIAN.
- 8 = COURT/LAW ENFORCEMENT - THE PATIENT WAS ADMITTED UPON THE DIRECTION OF A COURT OF LAW OR UPON THE REQUEST OF A LAW ENFORCEMENT AGENCY'S REPRESENTATIVE.
- 9 = INFORMATION NOT AVAILABLE - THE MEANS BY WHICH THE PATIENT WAS ADMITTED IS NOT KNOWN.
- A = TRANSFER FROM A CRITICAL ACCESS HOSPITAL - PATIENT WAS ADMITTED/REFERRED TO THIS FACILITY AS A TRANSFER FROM A CRITICAL ACCESS HOSPITAL.

FOR NEWBORN TYPE OF ADMISSION

- 1 = NORMAL DELIVERY - A BABY DELIVERED WITH OUT COMPLICATIONS.
- 2 = PREMATURE DELIVERY - A BABY DELIVERED WITH TIME AND/OR WEIGHT FACTORS QUALIFYING IT FOR PREMATURE STATUS.
- 3 = SICK BABY - A BABY DELIVERED WITH MEDICAL COMPLICATIONS, OTHER THAN THOSE RELATING TO PREMATURE STATUS.
- 4 = EXTRAMURAL BIRTH - A BABY DELIVERED IN A NONSTERILE ENVIRONMENT.
- 5-8 = RESERVED FOR NATIONAL ASSIGNMENT.

1 CLM_SRC_IP_ADMN_TB

CLAIM SOURCE OF INPATIENT ADMISSION TABLE

- 9 = INFORMATION NOT AVAILABLE.

1 CLM_SRVC_CLSFCTN_TYPE_TB

CLAIM SERVICE CLASSIFICATION TYPE TABLE

FOR FACILITY TYPE CODE 1 THRU 6, AND 9

- 1 = INPATIENT (INCLUDING PART A)
- 2 = HOSPITAL BASED OR INPATIENT (PART B ONLY)
OR HOME HEALTH VISITS UNDER PART B
- 3 = OUTPATIENT (HHA-A ALSO)
- 4 = OTHER (PART B)
- 5 = INTERMEDIATE CARE - LEVEL I
- 6 = INTERMEDIATE CARE - LEVEL II
- 7 = SUBACUTE INPATIENT
(FORMERLY INTERMEDIATE CARE - LEVEL III)
- 8 = SWING BEDS (USED TO INDICATE BILLING FOR
SNF LEVEL OF CARE IN A HOSPITAL WITH AN
APPROVED SWING BED AGREEMENT)
- 9 = RESERVED FOR NATIONAL ASSIGNMENT

FOR FACILITY TYPE CODE 7

- 1 = RURAL HEALTH
- 2 = HOSPITAL BASED OR INDEPENDENT RENAL
DIALYSIS FACILITY
- 3 = FREE-STANDING PROVIDER BASED FEDERALLY
QUALIFIED HEALTH CENTER (EFF 10/91)
- 4 = OTHER REHABILITATION FACILITY (ORF) AND
COMMUNITY MENTAL HEALTH CENTER (CMHC)
(EFF 10/91 - 3/97); ORF ONLY (EFF. 4/97)
- 5 = COMPREHENSIVE REHABILITATION CENTER
(CORF)
- 6 = COMMUNITY MENTAL HEALTH CENTER (CMHC) (EFF 4/97)
- 7-8 = RESERVED FOR NATIONAL ASSIGNMENT
- 9 = OTHER

FOR FACILITY TYPE CODE 8

- 1 = HOSPICE (NON-HOSPITAL BASED)
- 2 = HOSPICE (HOSPITAL BASED)
- 3 = AMBULATORY SURGICAL CENTER IN HOSPITAL
OUTPATIENT DEPARTMENT
- 4 = FREESTANDING BIRTHING CENTER

5 = CRITICAL ACCESS HOSPITAL (EFF. 10/99)
FORMERLY RURAL PRIMARY CARE HOSPITAL
(EFF. 10/94)
6-8 = RESERVED FOR NATIONAL USE
9 = OTHER

1 CLM_TRANS_TB

CLAIM TRANSACTION TABLE

0 = RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS (RNHCI)
BILL (PRIOR TO 8/00, CHRISTIAN SCIENCE BILL), SNF BILL,
OR STATE BUY-IN
1 = PSYCHIATRIC HOSPITAL FACILITY BILL OR DUMMY PSYCHIATRIC
2 = TUBERCULOSIS HOSPITAL FACILITY BILL
3 = GENERAL CARE HOSPITAL FACILITY BILL OR DUMMY LRD
4 = REGULAR SNF BILL
5 = HOME HEALTH AGENCY BILL (HHA)
6 = OUTPATIENT HOSPITAL BILL
C = CORF BILL - TYPE OF OP BILL IN THE HHA BILL FORMAT
(OBSOLETED 7/98)
H = HOSPICE BILL

1 CLM_VAL_TB

CLAIM VALUE TABLE

04 = INPATIENT PROFESSIONAL COMPONENT
CHARGES WHICH ARE COMBINED BILLED -
FOR USE ONLY BY SOME ALL INCLUSIVE
RATE HOSPITALS. (EFF 9/93)
05 = PROFESSIONAL COMPONENT INCLUDED IN
CHARGES AND ALSO BILLED SEPARATELY TO
CARRIER - FOR USE ON MEDICARE AND
MEDICAID BILLS IF THE STATE REQUESTS
THIS INFORMATION.
06 = MEDICARE BLOOD DEDUCTIBLE - TOTAL
CASH BLOOD DEDUCTIBLE (PART A BLOOD
DEDUCTIBLE).
07 = MEDICARE CASH DEDUCTIBLE (TERM 9/30/93)
RESERVED FOR NATIONAL ASSIGNMENT.
(EFF 10/93)
08 = MEDICARE PART A LIFETIME RESERVE AMOUNT
IN FIRST CALENDAR YEAR - LIFETIME RESERVE

AMOUNT CHARGED IN THE YEAR OF ADMISSION.
(NOT STORED IN NCH UNTIL 2/93)

09 = MEDICARE PART A COINSURANCE AMOUNT IN
THE FIRST CALENDAR YEAR - COINSURANCE
AMOUNT CHARGED IN THE YEAR OF ADMISSION.
(NOT STORED IN NCH UNTIL 2/93)

10 = MEDICARE PART A LIFETIME RESERVE AMOUNT
IN THE SECOND CALENDAR YEAR - LIFETIME
RESERVE AMOUNT CHARGED IN THE YEAR OF
DISCHARGE WHERE THE BILL SPANS TWO
CALENDAR YEARS.
(NOT STORED IN NCH UNTIL 2/93)

11 = MEDICARE PART A COINSURANCE AMOUNT IN
THE SECOND CALENDAR YEAR - COINSURANCE
AMOUNT CHARGED IN THE YEAR OF DISCHARGE
WHERE THE BILL SPANS TWO CALENDAR YEARS
(NOT STORED IN NCH UNTIL 2/93)

12 = AMOUNT IS THAT PORTION OF
HIGHER PRIORITY EGHP INSURANCE PAYMENT
MADE ON BEHALF OF AGED BENE
PROVIDER APPLIED TO MEDICARE
COVERED SERVICES ON THIS BILL.
SIX ZEROES INDICATE PROVIDER
CLAIMED CONDITIONAL MEDICARE PAYMENT.

13 = AMOUNT IS THAT PORTION OF HIGHER
PRIORITY EGHP INSURANCE PAYMENT MADE ON
BEHALF OF ESRD BENE PROVIDER
APPLIED TO MEDICARE COVERED SERVICES
ON THIS BILL. SIX ZEROES INDICATE
THE PROVIDER CLAIMED CONDITIONAL
MEDICARE PAYMENT.

14 = THAT PORTION OF PAYMENT FROM HIGHER
PRIORITY NO FAULT AUTO/OTHER
LIABILITY INSURANCE MADE ON BEHALF OF BENE
PROVIDER APPLIED TO MEDICARE COVERED
SERVICES ON THIS BILL. SIX ZEROES INDICATE
PROVIDER CLAIMED CONDITIONAL PAYMENT

15 = THAT PORTION OF A PAYMENT FROM A
HIGHER PRIORITY WC PLAN MADE ON BEHALF
OF A BENE THAT THE PROVIDER APPLIED TO
CLAIM VALUE TABLE

1 CLM_VAL_TB

MEDICARE COVERED SERVICES ON THIS BILL. SIX

- ZEROES INDICATE THE PROVIDER CLAIMED
CONDITIONAL MEDICARE PAYMENT.
- 16 = THAT PORTION OF A PAYMENT FROM
HIGHER PRIORITY PHS OR OTHER FEDERAL
AGENCY MADE ON BEHALF OF A
BENE THE PROVIDER APPLIED
TO MEDICARE COVERED SERVICES ON THIS
BILL. SIX ZEROES INDICATE
PROVIDER CLAIMED CONDITIONAL MEDICARE
PAYMENT.
- 17 = OPERATING OUTLIER AMOUNT - PROVIDERS DO
NOT REPORT THIS. FOR PAYER INTERNAL USE
ONLY. INDICATES THE AMOUNT OF DAY OR
COST OUTLIER PAYMENT TO BE MADE.
(DO NOT INCLUDE ANY PPS CAPITAL OUTLIER
PAYMENT IN THIS ENTRY).
- 18 = OPERATING DISPROPORTIONATE SHARE AMOUNT -
PROVIDERS DO NOT REPORT THIS. FOR
PAYER INTERNAL USE ONLY. INDICATES THE
DISPROPORTIONATE SHARE AMOUNT APPLICABLE
TO THE BILL. USE THE AMOUNT PROVIDED BY
THE DISPROPORTIONATE SHARE FIELD IN PRICER.
(DO NOT INCLUDE ANY PPS CAPITAL DSH ADJUST-
MENT IN THIS ENTRY).
- 19 = OPERATING INDIRECT MEDICAL EDUCATION AMOUNT -
PROVIDERS DO NOT REPORT THIS. FOR
PAYER INTERNAL USE ONLY. INDICATES THE
INDIRECT MEDICAL EDUCATION AMOUNT APPLICABLE
TO THE BILL. (DO NOT INCLUDE PPS CAPITAL
IME ADJUSTMENT IN THIS ENTRY).
- 20 = TOTAL PAYMENT SENT PROVIDER FOR CAPITAL
UNDER PPS, INCLUDING HSP, FSP, OUTLIER,
OLD CAPITAL, DSH ADJUSTMENT, IME
ADJUSTMENT, AND ANY EXCEPTION AMOUNT.
(USED 10/1/91 - 3/1/92 FOR PROVIDER
REPORTING. PAYER ONLY CODE EFF 9/93.)
- 21 = CATASTROPHIC - MEDICAID - ELIGIBILITY
REQUIREMENTS TO BE DETERMINED AT STATE
LEVEL. (MEDICAID SPECIFIC/DELETED 9/93)
- 22 = SURPLUS - MEDICAID - ELIGIBILITY
REQUIREMENTS TO BE DETERMINED AT STATE
LEVEL. (MEDICAID SPECIFIC/DELETED 9/93)
- 23 = RECURRING MONTHLY INCOME - MEDICAID -
ELIGIBILITY REQUIREMENTS TO BE

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CLM_VAL_TB

DETERMINED AT STATE LEVEL. (MEDICAID
SPECIFIC/DELETED 9/93)

24 = MEDICAID RATE CODE - MEDICAID -
ELIGIBILITY REQUIREMENTS TO BE
DETERMINED AT STATE LEVEL. (MEDICAID
SPECIFIC/DELETED 9/93)

31 = PATIENT LIABILITY AMOUNT - AMOUNT
SHOWN IS THAT WHICH YOU OR THE PRO
APPROVED TO CHARGE THE BENE FOR
NONCOVERED ACCOMMODATIONS, DIAGNOSTIC
PROCEDURES OR TREATMENTS.

37 = PINTS OF BLOOD FURNISHED - TOTAL
NUMBER OF PINTS OF WHOLE BLOOD OR UNITS
CLAIM VALUE TABLE

OF PACKED RED CELLS FURNISHED TO THE
PATIENT. (EFF 10/93)

38 = BLOOD DEDUCTIBLE PINTS - THE NUMBER
OF UNREPLACED PINTS OF WHOLE BLOOD OR
UNITS OF PACKED RED CELLS FURNISHED FOR
WHICH THE PATIENT IS RESPONSIBLE.
(EFF 10/93)

39 = PINTS OF BLOOD REPLACED - THE TOTAL
NUMBER OF PINTS OF WHOLE BLOOD OR UNITS
OF PACKED RED CELLS FURNISHED TO THE
PATIENT THAT HAVE BEEN REPLACED BY OR
ON BEHALF OF THE PATIENT. (EFF 10/93)

40 = NEW COVERAGE NOT IMPLEMENTED BY HMO -
AMOUNT SHOWN IS FOR INPATIENT CHARGES
COVERED BY HMO (EFF 3/92).
(USE THIS CODE WHEN THE BILL INCLUDES
INPATIENT CHARGES FOR NEWLY COVERED
SERVICES WHICH ARE NOT PAID BY HMO.)

41 = AMOUNT IS THAT PORTION OF
A PAYMENT FROM HIGHER PRIORITY BL
PROGRAM MADE ON BEHALF OF
BENE THE PROVIDER APPLIED
TO MEDICARE COVERED SERVICES ON THIS
BILL. SIX ZEROES INDICATE THE
PROVIDER CLAIMED CONDITIONAL MEDICARE
PAYMENT.

42 = AMOUNT IS THAT PORTION OF A PAYMENT
FROM HIGHER PRIORITY VA MADE ON BEHALF

OF BENE THE PROVIDER APPLIED
TO MEDICARE COVERED SERVICES ON THIS
BILL. SIX ZEROES INDICATE THE
PROVIDER CLAIMED CONDITIONAL MEDICARE
PAYMENT.

- 43 = DISABLED BENE UNDER AGE 65 WITH
LGHP - AMOUNT IS THAT PORTION OF
A PAYMENT FROM A HIGHER PRIORITY LGHP
MADE ON BEHALF OF A DISABLED MEDICARE
BENE THE PROVIDER APPLIED TO
MEDICARE COVERED SERVICES ON THIS BILL.
- 44 = AMOUNT PROVIDER AGREED TO ACCEPT FROM
PRIMARY PAYER WHEN AMOUNT LESS THAN CHARGES
BUT MORE THAN PAYMENT RECEIVED -
WHEN A LESSER AMOUNT IS RECEIVED AND THE
RECEIVED AMOUNT IS LESS THAN CHARGES, A
MEDICARE SECONDARY PAYMENT IS DUE.
- 46 = NUMBER OF GRACE DAYS - FOLLOWING THE
DATE OF THE PRO/UR DETERMINATION, THIS
IS THE NUMBER OF DAYS DETERMINED BY THE
PRO/UR TO BE NECESSARY TO ARRANGE FOR
THE PATIENT'S POST-DISCHARGE CARE.
(EFF 10/93)
- 47 = ANY LIABILITY INSURANCE - AMOUNT
IS THAT PORTION FROM A HIGHER PRIORITY
LIABILITY INSURANCE MADE ON BEHALF OF
MEDICARE BENE THE PROVIDER
IS APPLYING TO MEDICARE COVERED
SERVICES ON THIS BILL. (EFF 9/93)
- 48 = HEMOGLOBIN READING - THE LATEST
CLAIM VALUE TABLE

1 CLM_VAL_TB

HEMOGLOBIN READING TAKEN DURING THIS
BILLING CYCLE.

- 49 = LATEST HEMATOCRIT READING TAKEN
DURING BILLING CYCLE - USUALLY
REPORTED IN TWO POS. (A PERCENTAGE) TO
LEFT OF THE DOLLAR/CENT DELIMITER.
IF PROVIDED WITH A
A DECIMAL, USE THE 3RD POS. TO RIGHT
OF THE DELIMITER FOR THE THIRD DIGIT.
- 50 = PHYSICAL THERAPY VISITS - INDICATES
THE NUMBER OF PHYSICAL THERAPY

- VISITS FROM ONSET (AT BILLING PROVIDER)
THROUGH THIS BILLING PERIOD.
- 51 = OCCUPATIONAL THERAPY VISITS - INDICATES
THE NUMBER OF OCCUPATIONAL THERAPY
VISITS FROM ONSET (AT THE BILLING
PROVIDER) THROUGH THIS BILLING PERIOD.
- 52 = SPEECH THERAPY VISITS - INDICATES
THE NUMBER OF SPEECH THERAPY
VISITS FROM ONSET (AT BILLING PROVIDER)
THROUGH THIS BILLING PERIOD.
- 53 = CARDIAC REHABILITATION - INDICATES
THE NUMBER OF CARDIAC REHABILITATION
VISITS FROM ONSET (AT BILLING
PROVIDER) THROUGH THIS BILLING PERIOD.
- 54 = RESERVED FOR NATIONAL ASSIGNMENT.
- 55 = RESERVED FOR NATIONAL ASSIGNMENT.
- 56 = HOURS SKILLED NURSING PROVIDED - THE
NUMBER OF HOURS SKILLED NURSING
PROVIDED DURING THE BILLING PERIOD. COUNT
ONLY HOURS SPENT IN THE HOME.
- 57 = HOME HEALTH VISIT HOURS - THE NUMBER
OF HOME HEALTH AIDE SERVICES PROVIDED
DURING THE BILLING PERIOD. COUNT ONLY
THE HOURS SPENT IN THE HOME.
- 58 = ARTERIAL BLOOD GAS - ARTERIAL BLOOD
GAS VALUE AT BEGINNING OF EACH REPORTING
PERIOD FOR OXYGEN THERAPY. THIS
VALUE OR VALUE 59 WILL BE REQUIRED ON
THE INITIAL BILL FOR OXYGEN THERAPY AND
ON THE FOURTH MONTH'S BILL.
- 59 = OXYGEN SATURATION - OXYGEN SATURATION
AT THE BEGINNING OF EACH REPORTING
PERIOD FOR OXYGEN THERAPY. THIS VALUE OR
VALUE 58 WILL BE REQUIRED ON THE
INITIAL BILL FOR OXYGEN THERAPY AND ON
THE FOURTH MONTH'S BILL.
- 60 = HHA BRANCH MSA - MSA IN WHICH HHA
BRANCH IS LOCATED.
- 61 = LOCATION OF HHA SERVICE OR HOSPICE
SERVICE - THE BALANCED BUDGET ACT
(BBA) REQUIRES THAT THE GEOGRAPHIC
LOCATION OF WHERE THE SERVICE WAS
PROVIDED BE FURNISHED INSTEAD OF THE
GEOGRAPHIC LOCATION OF THE PROVIDER.

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CLM_VAL_TB

(EFF. 10/1/97)

62 = NUMBER OF PART A HOME HEALTH VISITS
ACCRUED DURING A PERIOD OF CONTINUOUS
CLAIM VALUE TABLE

CARE - NECESSITATED BY THE CHANGE IN
PAYMENT BASIS UNDER HH PPS (EFF. 10/00)

63 = NUMBER OF PART B HOME HEALTH VISITS
ACCRUED DURING A PERIOD OF CONTINUOUS
CARE - NECESSITATED BY THE CHANGE IN
PAYMENT BASIS UNDER HH PPS (EFF. 10/00)

64 = AMOUNT OF HOME HEALTH PAYMENTS ATTRIBUTED
TO THE PART A TRUST FUND IN A PERIOD
OF CONTINUOUS CARE - NECESSITATED BY THE
CHANGE IN PAYMENT BASIS UNDER HH PPS
(EFF. 10/00)

65 = AMOUNT OF HOME HEALTH PAYMENTS ATTRIBUTED
TO THE PART B TRUST FUND IN A PERIOD
OF CONTINUOUS CARE - NECESSITATED BY THE
CHANGE IN PAYMENT BASIS UNDER HH PPS
(EFF. 10/00)

66 = RESERVED FOR NATIONAL ASSIGNMENT.

67 = PERITONEAL DIALYSIS - THE NUMBER OF
HOURS OF PERITONEAL DIALYSIS PROVIDED
DURING THE BILLING PERIOD (ONLY THE
HOURS SPENT IN THE HOME).
(EFF. 10/97)

68 = EPO DRUG - NUMBER OF UNITS OF EPO
ADMINISTERED RELATING TO THE BILLING
PERIOD.

69 = RESERVED FOR NATIONAL ASSIGNMENT

70 = INTEREST AMOUNT - (PROVIDERS DO NOT
REPORT THIS.) REPORT THE AMOUNT
APPLIED TO THIS BILL.

71 = FUNDING OF ESRD NETWORKS - (PROVIDERS
DO NOT REPORT THIS.) REPORT THE
AMOUNT THE MEDICARE PAYMENT WAS
REDUCED TO HELP FUND THE ESRD NETWORKS.

72 = FLAT RATE SURGERY CHARGE - CODE
INDICATES THE AMOUNT OF THE CHARGE FOR
OUTPATIENT SURGERY WHERE THE HOSPITAL
HAS SUCH A CHARGING STRUCTURE.

73 = DRUG DEDUCTIBLE - (FOR INTERNAL USE BY

THIRD PARTY PAYERS ONLY). REPORT THE
AMOUNT OF THE DRUG DEDUCTIBLE TO BE
APPLIED TO THE CLAIM.

74 = DRUG COINSURANCE - (FOR INTERNAL USE
BY THIRD PARTY PAYERS ONLY). REPORT
THE AMOUNT OF DRUG COINSURANCE TO BE
APPLIED TO THE CLAIM.

75 = GRAMM/RUDMAN/HOLLINGS - (PROVIDERS DO
NOT REPORT THIS.) REPORT THE AMOUNT OF
THE SEQUESTRATION APPLIED TO THIS BILL.

76 = REPORT PROVIDER'S PERCENTAGE OF
BILLED CHARGES INTERIM RATE DURING
BILLING PERIOD. APPLIES TO OP
HOSPITAL, SNF AND HHA CLAIMS
WHERE INTERIM RATE IS APPLICABLE.
REPORT TO LEFT OF DOLLAR/CENTS DELIMITER.
(TP PAYERS INTERNAL USE ONLY)

77 = PAYER CODE - THIS CODES IS SET
ASIDE FOR PAYER USE ONLY. PROVIDERS
DO NOT REPORT THESE CODES.

CLAIM VALUE TABLE

78 = PAYER CODE - THIS CODES IS SET
ASIDE FOR PAYER USE ONLY. PROVIDERS
DO NOT REPORT THESE CODES.

79 = PAYER CODE - THIS CODE IS SET
ASIDE FOR PAYER USE ONLY. PROVIDERS
DO NOT REPORT THESE CODES.

80 - 99 = RESERVED FOR STATE ASSIGNMENT.

A1 = DEDUCTIBLE PAYER A - THE AMOUNT
ASSUMED BY THE PROVIDER TO BE APPLIED
TO THE PATIENT'S DEDUCTIBLE AMOUNT
INVOLVING THE INDICATED PAYER. (EFF 10/93)
- PRIOR VALUE 07

A2 = COINSURANCE PAYER A - THE AMOUNT ASSUMED
BY THE PROVIDER TO BE APPLIED TO THE
PATIENT'S PART B COINSURANCE AMOUNT
INVOLVING THE INDICATED PAYER. (EFF 10/93)

A4 = SELF-ADMINISTERED DRUGS ADMINISTERED IN AN
EMERGENCY SITUATION - ORDINARILY THE ONLY
NONCOVERED SELF-ADMINISTERED DRUG
PAID FOR UNDER MEDICARE IN AN EMERGENCY
SITUATION IS INSULIN ADMINISTERED TO A

1 CLM_VAL_TB

PATIENT IN A DIABETIC COMA. (EFF 7/97)

B1 = DEDUCTIBLE PAYER B - THE AMOUNT
ASSUMED BY THE PROVIDER TO BE APPLIED
TO THE PATIENT'S DEDUCTIBLE AMOUNT
INVOLVING THE INDICATED PAYER. (EFF 10/93)
- PRIOR VALUE 07

B2 = COINSURANCE PAYER B - THE AMOUNT ASSUMED
BY THE PROVIDER TO BE APPLIED TO THE
PATIENT'S PART B COINSURANCE AMOUNT
INVOLVING THE INDICATED PAYER. (EFF 10/93)

C1 = DEDUCTIBLE PAYER C - THE AMOUNT
ASSUMED BY THE PROVIDER TO BE APPLIED
TO THE PATIENT'S DEDUCTIBLE AMOUNT
INVOLVING THE INDICATED PAYER. (EFF 10/93)
- PRIOR VALUE 07

C2 = COINSURANCE PAYER C - THE AMOUNT ASSUMED
BY THE PROVIDER TO BE APPLIED TO THE
PATIENT'S PART B COINSURANCE AMOUNT
INVOLVING THE INDICATED PAYER. (EFF 10/93)

Y1 = PART A DEMO PAYMENT - PORTION OF THE
PAYMENT DESIGNATED AS REIMBURSEMENT FOR
PART A SERVICES PER THE ORD CONTRACT. NO
DEDUCTIBLE OR COINSURANCE HAS BEEN
APPLIED. (EFF. 5/97)

Y2 = PART B DEMO PAYMENT - PORTION OF THE
PAYMENT DESIGNATED AS REIMBURSEMENT FOR
PART B SERVICES FOR THE ORD CONTRACT.
NO DEDUCTIBLE OR COINSURANCE HAS BEEN
APPLIED. (EFF. 5/97)

Y3 = PART B COINSURANCE - AMOUNT OF PART B
COINSURANCE APPLIED BY THE INTERMEDIARY
TO THIS DEMO CLAIM. (EFF. 5/97)

Y4 = CONVENTIONAL PROVIDER PART A PAYMENT -
AMOUNT MEDICARE WOULD HAVE REIMBURSED
THE PROVIDER FOR PART A SERVICES IF
THERE HAD BEEN NO DEMO. (EFF. 5/97)

1 CTGRY_EQTBL_BENE_IDENT_TB

CATEGORY EQUATABLE BENEFICIARY IDENTIFICATION CODE (BIC) TABLE

NCH BIC

SSA CATEGORIES

A = A;J1;J2;J3;J4;M;M1;T;TA
 B = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
 TB (F) ; TD (F) ; TE (F) ; TW (F)
 B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB (M)
 TD (M) ; TE (M) ; TW (M)
 B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
 W7;TG (F) ; TL (F) ; TR (F) ; TX (F)
 B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG (M)
 TL (M) ; TR (M) ; TX (M)
 B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
 W8;TH (F) ; TM (F) ; TS (F) ; TY (F)
 BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
 WC;TJ (F) ; TN (F) ; TT (F) ; TZ (F)
 BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
 WJ;TK (F) ; TP (F) ; TU (F) ; TV (F)
 BG = BG;DH;DQ;DS;EF;EJ;W5;TH (M) ; TM (M) ; TS (M)
 TY (M)
 BH = BH;DJ;DR;DX;EG;EK;WB;TJ (M) ; TN (M) ; TT (M)
 TZ (M)
 BJ = BJ;DK;DT;DZ;EH;EM;WG;TK (M) ; TP (M) ; TU (M)
 TV (M)
 C1 = C1;TC
 C2 = C2;T2
 C3 = C3;T3
 C4 = C4;T4
 C5 = C5;T5
 C6 = C6;T6
 C7 = C7;T7
 C8 = C8;T8
 C9 = C9;T9
 F1 = F1;TF
 F2 = F2;TQ
 F3-F8 = EQUATABLE ONLY TO ITSELF (E.G., F3 IS
 EQUATABLE TO F3)
 CA-CZ = EQUATABLE ONLY TO ITSELF. (E.G., CA IS
 ONLY EQUATABLE TO CA)

 RRB CATEGORIES

10 = 10
 11 = 11
 13 = 13;17
 14 = 14;16

15 = 15
43 = 43
45 = 45
46 = 46
80 = 80
83 = 83
84 = 84;86
85 = 85

1 DMERC_LINE_SCRN_RSLT_IND_TB

DMERC LINE SCREEN RESULT INDICATOR TABLE

A = DENIED FOR LACK OF MEDICAL NECESSITY;
HIGHEST LEVEL OF REVIEW WAS AUTOMATED
LEVEL I REVIEW
B = REDUCED (PARTIALLY DENIED) FOR LACK
OF MEDICAL NECESSITY; HIGHEST LEVEL
OF REVIEW WAS AUTOMATED LEVEL I REVIEW
C = DENIED AS STATUTORILY NONCOVERED;
HIGHEST LEVEL OF REVIEW WAS AUTOMATED
LEVEL I REVIEW
D = RESERVED FOR FUTURE USE
E = PAID AFTER AUTOMATED LEVEL I REVIEW
F = DENIED FOR LACK OF MEDICAL NECESSITY;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL I REVIEW
G = REDUCED (PARTIALLY DENIED) FOR LACK
OF MEDICAL NECESSITY; HIGHEST LEVEL
OF REVIEW WAS MANUAL LEVEL I REVIEW
H = DENIED AS STATUTORILY NONCOVERED;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL I REVIEW
I = DENIED FOR CODING/UNBUNDLING REASONS;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL I REVIEW
J = PAID AFTER MANUAL LEVEL I REVIEW
K = DENIED FOR LACK OF MEDICAL NECESSITY;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL II REVIEW
L = REDUCED (PARTIALLY DENIED) FOR LACK
OF MEDICAL NECESSITY; HIGHEST LEVEL
OF REVIEW WAS MANUAL LEVEL II REVIEW
M = DENIED AS STATUTORILY NONCOVERED;

HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL II REVIEW
N = DENIED FOR CODING/UNBUNDLING REASONS;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL II REVIEW
O = PAID AFTER MANUAL LEVEL II REVIEW
P = DENIED FOR LACK OF MEDICAL NECESSITY;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL III REVIEW
Q = REDUCED (PARTIALLY DENIED) FOR LACK
OF MEDICAL NECESSITY; HIGHEST LEVEL
OF REVIEW WAS MANUAL LEVEL III REVIEW
R = DENIED AS STATUTORILY NONCOVERED;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL III REVIEW
S = DENIED FOR CODING/UNBUNDLING REASONS;
HIGHEST LEVEL OF REVIEW WAS MANUAL
LEVEL III REVIEW
T = PAID AFTER MANUAL LEVEL III REVIEW

1 DMERC_LINE_SUPLR_TYPE_TB

DMERC LINE SUPPLIER TYPE TABLE

0 = CLINICS, GROUPS, ASSOCIATIONS,
PARTNERSHIPS, OR OTHER ENTITIES
FOR WHOM THE CARRIER'S OWN ID NUMBER
HAS BEEN ASSIGNED.
1 = PHYSICIANS OR SUPPLIERS BILLING AS
SOLO PRACTITIONERS FOR WHOM SSN'S ARE
SHOWN IN THE PHYSICIAN ID CODE FIELD.
2 = PHYSICIANS OR SUPPLIERS BILLING AS
SOLO PRACTITIONERS FOR WHOM THE CARRIER'S
OWN PHYSICIAN ID CODE IS SHOWN.
3 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
FOR WHOM EI NUMBERS ARE USED IN CODING THE
ID FIELD.
4 = SUPPLIERS (OTHER THAN SOLE PROPRIETORSHIP)
FOR WHOM THE CARRIER'S OWN CODE HAS BEEN
SHOWN.
5 = INSTITUTIONAL PROVIDERS AND
INDEPENDENT LABORATORIES FOR WHOM EI
NUMBERS ARE USED IN CODING THE ID FIELD.
6 = INSTITUTIONAL PROVIDERS AND

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1      DRG_OUTLIER_STAY_TB      DIAGNOSIS RELATED GROUP OUTLIER PATIENT STAY TABLE
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*** NON-PPS ONLY ***

1	FI_CLM_ACTN_TB	FISCAL INTERMEDIARY CLAIM ACTION TABLE
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<http://hcfanet.hcfa.gov/hpages/ois/metadata/dataadmn/RIF/UTLIPSNI.HTM>

6 = FORCE ACTION CODE 2
8 = BENEFITS REFUSED (FOR INPATIENT BILLS,
AN 'R' NONPAYMENT CODE MUST ALSO BE
PRESENT
9 = PAYMENT REQUESTED (USED ON BILLS THAT
REPLACE PREVIOUSLY-SUBMITTED BENEFITS-
REFUSED BILLS, ACTION CODE 8. IN SUCH
CASES A DEBIT/CREDIT PAIR IS NOT RE-
QUIRED. FOR INPATIENT BILLS, A 'P'
SHOULD BE ENTERED IN THE NONPAYMENT
CODE.)

1

FI_NUM_TB

FISCAL INTERMEDIARY NUMBER TABLE

00010 = ALABAMA BC
00020 = ARKANSAS BC
00030 = ARIZONA BC
00040 = CALIFORNIA BC (TERM. 12/00)
00050 = NEW MEXICO BC/CO
00060 = CONNECTICUT BC
00070 = DELAWARE BC - TERMINATED 2/98
00080 = FLORIDA BC
00090 = FLORIDA BC
00101 = GEORGIA BC
00121 = ILLINOIS - HCSC
00123 = MICHIGAN - HCSC
00130 = INDIANA BC/ADMINISTAR FEDERAL
00131 = ILLINOIS - ADMINISTAR
00140 = IOWA - WELLMARK (TERM. 6/2000)
00150 = KANSAS BC
00160 = KENTUCKY/ADMINISTAR
00180 = MAINE BC
00181 = MAINE BC - MASSACHUSETTS
00190 = MARYLAND BC
00200 = MASSACHUSETTS BC - TERMINATED 7/97
00210 = MICHIGAN BC - TERMINATED 9/94
00220 = MINNESOTA BC
00230 = MISSISSIPPI BC
00231 = MISSISSIPPI BC/LA
00232 = MISSISSIPPI BC
00241 = MISSOURI BC - TERMINATED 9/92
00250 = MONTANA BC

00260 = NEBRASKA BC
00270 = NEW HAMPSHIRE/VT BC
00280 = NEW JERSEY BC (TERM. 8/2000)
00290 = NEW MEXICO BC - TERMINATED 11/95
00308 = EMPIRE BC
00310 = NORTH CAROLINA BC
00320 = NORTH DAKOTA BC
00332 = COMMUNITY MUTUAL INS CO; OHIO-ADMINISTAR
00340 = OKLAHOMA BC
00350 = OREGON BC
00351 = OREGON BC/ID.
00355 = OREGON-CWF
00362 = INDEPENDENCE BC - TERMINATED 8/97
00363 = VERITUS, INC (PITTS)
00370 = RHODE ISLAND BC
00380 = SOUTH CAROLINA BC
00390 = TENNESSEE BC
00400 = TEXAS BC
00410 = UTAH BC
00423 = VIRGINIA BC; TRIGON
00430 = WASHINGTON/ALASKA BC
00450 = WISCONSIN BC
00452 = MICHIGAN - WISCONSIN BC
00454 = UNITED GOVERNMENT SERVICES -
WISCONSIN BC (EFF. 12/00)
00460 = WYOMING BC
00468 = N CAROLINA BC/CPRTIVA
00993 = BC/BS ASSOC.
17120 = HAWAII MEDICAL SERVICE

FISCAL INTERMEDIARY NUMBER TABLE

50333 = TRAVELERS; CONNECTICUT UNITED HEALTHCARE
(TERMINATED - DATE UNKNOWN)
51051 = AETNA CALIFORNIA - TERMINATED 6/97
51070 = AETNA CONNECTICUT - TERMINATED 6/97
51100 = AETNA FLORIDA - TERMINATED 6/97
51140 = AETNA ILLINOIS - TERMINATED 6/97
51390 = AETNA PENNSYLVANIA - TERMINATED 6/97
52280 = MUTUAL OF OMAHA
57400 = COOPERATIVE, SAN JUAN, PR
61000 = AETNA

1 FI_NUM_TB

1 FI_RQST_CLM_CNCL_RSN_TB

CLAIM CANCEL REASON CODE TABLE

C = COVERAGE TRANSFER
D = DUPLICATE BILLING
H = OTHER OR BLANK
L = COMBINING TWO BENEFICIARY MASTER RECORDS
P = PLAN TRANSFER
S = SCRAMBLE
*****FOR ACTION CODE 4 *****
*****EFFECTIVE WITH HHPPS - 10/00*****
A = RAP/FINAL CLAIM/LUPA IS CANCELLED BY INTERME-
DIARY. DOES NOT DELETE EPISODE. DO NOT SET
CANCELLATION INDICATOR.
B = RAP/FINAL CLAIM/LUPA IS CANCELLED BY INTERME-
DIARY. DOES NOT DELETE EPISODE. SET
CANCELLATION INDICATOR TO 1.
E = RAP/FINAL CLAIM/LUPA IS CANCELLED BY INTERME-
DIARY. REMOVE EPISODE.
F = RAP/FINAL CLAIM/LUPA IS CANCELLED BY PROVIDER.
REMOVE EPISODE.

1 GEO_SSA_STATE_TB

STATE TABLE

01 = ALABAMA
02 = ALASKA
03 = ARIZONA
04 = ARKANSAS
05 = CALIFORNIA
06 = COLORADO
07 = CONNECTICUT
08 = DELAWARE
09 = DISTRICT OF COLUMBIA
10 = FLORIDA
11 = GEORGIA
12 = HAWAII
13 = IDAHO
14 = ILLINOIS
15 = INDIANA
16 = IOWA
17 = KANSAS
18 = KENTUCKY

19 = LOUISIANA
20 = MAINE
21 = MARYLAND
22 = MASSACHUSETTS
23 = MICHIGAN
24 = MINNESOTA
25 = MISSISSIPPI
26 = MISSOURI
27 = MONTANA
28 = NEBRASKA
29 = NEVADA
30 = NEW HAMPSHIRE
31 = NEW JERSEY
32 = NEW MEXICO
33 = NEW YORK
34 = NORTH CAROLINA
35 = NORTH DAKOTA
36 = OHIO
37 = OKLAHOMA
38 = OREGON
39 = PENNSYLVANIA
40 = PUERTO RICO
41 = RHODE ISLAND
42 = SOUTH CAROLINA
43 = SOUTH DAKOTA
44 = TENNESSEE
45 = TEXAS
46 = UTAH
47 = VERMONT
48 = VIRGIN ISLANDS
49 = VIRGINIA
50 = WASHINGTON
51 = WEST VIRGINIA
52 = WISCONSIN
53 = WYOMING
54 = AFRICA
55 = ASIA
56 = CANADA & ISLANDS
57 = CENTRAL AMERICA AND WEST INDIES
58 = EUROPE
59 = MEXICO

1 GEO_SSA_STATE_TB

STATE TABLE

60 = OCEANIA
61 = PHILIPPINES
62 = SOUTH AMERICA
63 = U.S. POSSESSIONS
64 = AMERICAN SAMOA
65 = GUAM
66 = SAIPAN
97 = NORTHERN MARIANAS
98 = GUAM
99 = WITH 000 COUNTY CODE IS AMERICAN SAMOA;
OTHERWISE UNKNOWN

1 HCFA_PRVDR_SPCLTY_TB

HCFA PROVIDER SPECIALTY TABLE

PRIOR TO 5/92

01 = GENERAL PRACTICE
02 = GENERAL SURGERY
03 = ALLERGY (REVISED 10/91 TO MEAN ALLERGY/
IMMUNOLOGY)
04 = OTOLOGY, LARYNGOLOGY, RHINOLOGY
REVISED 10/91 TO MEAN OTOLARYNGOLOGY)
05 = ANESTHESIOLOGY
06 = CARDIOVASCULAR DISEASE (REVISED 10/91
TO MEAN CARDIOLOGY)
07 = DERMATOLOGY
08 = FAMILY PRACTICE
09 = GYNECOLOGY--OSTEOPATHS ONLY (DELETED
10/91; CHANGED TO '16')
10 = GASTROENTEROLOGY
11 = INTERNAL MEDICINE
12 = MANIPULATIVE THERAPY (OSTEOPATHS ONLY)
(REVISED 10/91 TO MEAN OSTEOPATHIC
MANIPULATIVE THERAPY)
13 = NEUROLOGY
14 = NEUROLOGICAL SURGERY (REVISED 10/91 TO
MEAN NEUROSURGERY)
15 = OBSTETRICS--OSTEOPATHS ONLY (DELETED
10/91; CHANGED TO '16')
16 = OB-GYNECOLOGY
17 = OPHTHALMOLOGY, OTOLOGY, LARYNGOLOGY
RHINOLOGY--OSTEOPATHS ONLY (DELETED

10/91; CHANGED TO '18' IF PHYSICIANS
PRACTICE IS MORE THAN 50% OPHTHALMOLOGY
OR TO '04' IF PHYSICIAN'S PRACTICE IS
MORE THAN 50% OTOLARYNGOLOGY. IF
PRACTICE IS 50/50, CHOOSE SPECIALTY
WITH GREATER ALLOWED CHARGES.

18 = OPHTHALMOLOGY
19 = ORAL SURGERY (DENTISTS ONLY)
20 = ORTHOPEDIC SURGERY
21 = PATHOLOGIC ANATOMY, CLINICAL PATHOLOGY-
OSTEOPATHS ONLY (DELETED 10/91;
CHANGED TO '22')
22 = PATHOLOGY
23 = PERIPHERAL VASCULAR DISEASE OR SURGERY
(DELETED 10/91; CHANGED TO '76')
24 = PLASTIC SURGERY (REVISED TO MEAN
PLASTIC AND RECONSTRUCTIVE SURGERY).
25 = PHYSICAL MEDICINE AND REHABILITATION
26 = PSYCHIATRY
27 = PSYCHIATRY, NEUROLOGY (OSTEOPATHS ONLY)
(DELETED 10/91; CHANGED TO '86')
28 = PROCTOLOGY (REVISED 10/91 TO MEAN
COLORECTAL SURGERY).
29 = PULMONARY DISEASE
30 = RADIOLOGY (REVISED 10/91 TO MEAN
DIAGNOSTIC RADIOLOGY)
31 = ROENTGENOLOGY, RADIOLOGY (OSTEOPATHS)
(DELETED 10/91; CHANGED TO '30')
32 = RADIATION THERAPY--OSTEOPATHS (DELETED
HCFA PROVIDER SPECIALTY TABLE

1 HCFA_PRVDR_SPCLTY_TB

10/91; CHANGED TO '92')
33 = THORACIC SURGERY
34 = UROLOGY
35 = CHIROPRACTOR, LICENSED (REVISED 10/91
TO MEAN CHIROPRACTIC)
36 = NUCLEAR MEDICINE
37 = PEDIATRICS (REVISED 10/91 TO MEAN
PEDIATRIC MEDICINE)
38 = GERIATRICS (REVISED 10/91 TO MEAN
GERIATRIC MEDICINE)
39 = NEPHROLOGY
40 = HAND SURGERY

- 41 = OPTOMETRIST - SERVICES RELATED TO
CONDITION OF APHAKIA (REVISED 10/91 TO
MEAN OPTOMETRIST)
- 42 = CERTIFIED NURSE MIDWIFE (ADDED 7/88)
- 43 = CERTIFIED REGISTERED NURSE ANESTHETIST
(REVISED 10/91 TO MEAN CRNA,
ANESTHESIA ASSISTANT)
- 44 = INFECTIOUS DISEASE
- 46 = ENDOCRINOLOGY (ADDED 10/91)
- 48 = PODIATRY - SURGERY CHIROPODY (REVISED
10/91 TO MEAN PODIATRY)
- 49 = MISCELLANEOUS (INCLUDE ASCS)
- 51 = MEDICAL SUPPLY COMPANY WITH C.O.
CERTIFICATION (CERTIFIED ORTHOTIST -
CERTIFIED BY AMERICAN BOARD FOR
CERTIFICATION IN PROSTHETICS AND
ORTHOTICS).
- 52 = MEDICAL SUPPLY COMPANY WITH C.P.
CERTIFICATION (CERTIFIED PROSTHETIST -
CERTIFIED BY AMERICAN BOARD FOR
CERTIFICATION IN PROSTHETICS AND ORTHOTICS) .
- 53 = MEDICAL SUPPLY COMPANY WITH C.P.O.
CERTIFICATION (CERTIFIED PROSTHETIST -
ORTHOTIST - CERTIFIED BY AMERICAN
BOARD FOR CERTIFICATION IN PROSTHETICS
AND ORTHOTICS) .
- 54 = MEDICAL SUPPLY COMPANY NOT INCLUDED IN
51, 52, OR 53.
- 55 = INDIVIDUAL CERTIFIED ORTHOTIST
- 56 = INDIVIDUAL CERTIFIED PROSTHETIST
- 57 = INDIVIDUAL CERTIFIED PROSTHETIST -
ORTHOTIST
- 58 = INDIVIDUALS NOT INCLUDED IN 55,56 OR 57
- 59 = AMBULANCE SERVICE SUPPLIER (E.G.
PRIVATE AMBULANCE COMPANIES, FUNERAL
HOMES, ETC.)
- 60 = PUBLIC HEALTH OR WELFARE AGENCIES
(FEDERAL, STATE, AND LOCAL)
- 61 = VOLUNTARY HEALTH OR CHARITABLE AGENCIES
(E.G. NATIONAL CANCER SOCIETY, NATIONAL
HEART ASSOCIATION, CATHOLIC CHARITIES)
- 62 = PSYCHOLOGIST--BILLING INDEPENDENTLY
- 63 = PORTABLE X-RAY SUPPLIER--BILLING
INDEPENDENTLY (REVISED 10/91 TO MEAN

1 HCFA_PRVDR_SPCLTY_TB

PORTABLE X-RAY SUPPLIER)
64 = AUDIOLOGIST (BILLING INDEPENDENTLY)
HCFA PROVIDER SPECIALTY TABLE

65 = PHYSICAL THERAPIST (INDEPENDENT PRACTICE)
66 = RHEUMATOLOGY (ADDED 10/91)
67 = OCCUPATIONAL THERAPIST--INDEPENDENT
PRACTICE
68 = CLINICAL PSYCHOLOGIST
69 = INDEPENDENT LABORATORY--BILLING
INDEPENDENTLY (REVISED 10/91 TO MEAN
INDEPENDENT CLINICAL LABORATORY --
BILLING INDEPENDENTLY)
70 = CLINIC OR OTHER GROUP PRACTICE, EXCEPT
GROUP PRACTICE PREPAYMENT PLAN (GPPP)
71 = GROUP PRACTICE PREPAYMENT PLAN - DIAGNOSTIC
X-RAY (DO NOT USE AFTER 1/92)
72 = GROUP PRACTICE PREPAYMENT PLAN - DIAGNOSTIC
LABORATORY (DO NOT USE AFTER 1/92)
73 = GROUP PRACTICE PREPAYMENT PLAN -
PHYSIOTHERAPY (DO NOT USE AFTER 1/92)
74 = GROUP PRACTICE PREPAYMENT PLAN - OCCUPATIONAL
THERAPY (DO NOT USE AFTER 1/92)
75 = GROUP PRACTICE PREPAYMENT PLAN - OTHER
MEDICAL CARE (DO NOT USE AFTER 1/92)
76 = PERIPHERAL VASCULAR DISEASE
(ADDED 10/91)
77 = VASCULAR SURGERY (ADDED 10/91)
78 = CARDIAC SURGERY (ADDED 10/91)
79 = ADDICTION MEDICINE (ADDED 10/91)
80 = CLINICAL SOCIAL WORKER (1991)
81 = CRITICAL CARE-INTENSIVISTS (ADDED 10/91)
82 = OPHTHALMOLOGY, CATARACTS SPECIALTY
(ADDED 10/91; USED ONLY UNTIL 5/92)
83 = HEMATOLOGY/ONCOLOGY (ADDED 10/91)
84 = PREVENTIVE MEDICINE (ADDED 10/91)
85 = MAXILLOFACIAL SURGERY (ADDED 10/91)
86 = NEUROPSYCHIATRY (ADDED 10/91)
87 = ALL OTHER (E.G. DRUG AND DEPARTMENT
STORES) (REVISED 10/91 TO MEAN ALL
OTHER SUPPLIERS)
88 = UNKNOWN (REVISED 10/91 TO MEAN
PHYSICIAN ASSISTANT)

90 = MEDICAL ONCOLOGY (ADDED 10/91)
91 = SURGICAL ONCOLOGY (ADDED 10/91)
92 = RADIATION ONCOLOGY (ADDED 10/91)
93 = EMERGENCY MEDICINE (ADDED 10/91)
94 = INTERVENTIONAL RADIOLOGY (ADDED 10/91)
95 = INDEPENDENT PHYSIOLOGICAL LABORATORY
(ADDED 10/91)
96 = UNKNOWN PHYSICIAN SPECIALTY
(ADDED 10/91)
99 = UNKNOWN--INCL. SOCIAL WORKER'S
PSYCHIATRIC SERVICES (REVISED 10/91 TO
MEAN UNKNOWN SUPPLIER/PROVIDER)

EFFECTIVE 5/92

00 = CARRIER WIDE
01 = GENERAL PRACTICE
02 = GENERAL SURGERY
03 = ALLERGY/IMMUNOLOGY

1 HCFA_PRVDR_SPCLTY_TB

HCFA PROVIDER SPECIALTY TABLE

04 = OTOLARYNGOLOGY
05 = ANESTHESIOLOGY
06 = CARDIOLOGY
07 = DERMATOLOGY
08 = FAMILY PRACTICE
09 = GYNECOLOGY (OSTEOPATHS ONLY)
(DISCONTINUED 5/92 USE CODE 16)
10 = GASTROENTEROLOGY
11 = INTERNAL MEDICINE
12 = OSTEOPATHIC MANIPULATIVE THERAPY
13 = NEUROLOGY
14 = NEUROSURGERY
15 = OBSTETRICS (OSTEOPATHS ONLY)
(DISCONTINUED 5/92 USE CODE 16)
16 = OBSTETRICS/GYNECOLOGY
17 = OPHTHALMOLOGY, OTOLOGY, LARYNGOLOGY,
RHINOLOGY (OSTEOPATHS ONLY)
(DISCONTINUED 5/92 USE CODES 18 OR 04
DEPENDING ON PERCENTAGE OF PRACTICE)
18 = OPHTHALMOLOGY
19 = ORAL SURGERY (DENTISTS ONLY)
20 = ORTHOPEDIC SURGERY

21 = PATHOLOGIC ANATOMY, CLINICAL
PATHOLOGY (OSTEOPATHS ONLY)
(DISCONTINUED 5/92 USE CODE 22)
22 = PATHOLOGY
23 = PERIPHERAL VASCULAR DISEASE, MEDICAL
OR SURGICAL (OSTEOPATHS ONLY)
(DISCONTINUED 5/92 USE CODE 76)
24 = PLASTIC AND RECONSTRUCTIVE SURGERY
25 = PHYSICAL MEDICINE AND REHABILITATION
26 = PSYCHIATRY
27 = PSYCHIATRY, NEUROLOGY (OSTEOPATHS
ONLY) (DISCONTINUED 5/92 USE CODE 86)
28 = COLORECTAL SURGERY (FORMERLY
PROCTOLOGY)
29 = PULMONARY DISEASE
30 = DIAGNOSTIC RADIOLOGY
31 = ROENTGENOLOGY, RADIOLOGY (OSTEOPATHS
ONLY) (DISCONTINUED 5/92 USE CODE 30)
32 = RADIATION THERAPY (OSTEOPATHS ONLY)
(DISCONTINUED 5/92 USE CODE 92)
33 = THORACIC SURGERY
34 = UROLOGY
35 = CHIROPRACTIC
36 = NUCLEAR MEDICINE
37 = PEDIATRIC MEDICINE
38 = GERIATRIC MEDICINE
39 = NEPHROLOGY
40 = HAND SURGERY
41 = OPTOMETRY (REVISED 10/93 TO
MEAN OPTOMETRIST)
42 = CERTIFIED NURSE MIDWIFE (EFF 1/87)
43 = CRNA, ANESTHESIA ASSISTANT
(EFF 1/87)
44 = INFECTIOUS DISEASE
45 = MAMMOGRAPHY SCREENING CENTER
46 = ENDOCRINOLOGY (EFF 5/92)

HCFA PROVIDER SPECIALTY TABLE

47 = INDEPENDENT DIAGNOSTIC TESTING FACILITY
(IDTF) (EFF. 6/98)
48 = PODIATRY
49 = AMBULATORY SURGICAL CENTER
(FORMERLY MISCELLANEOUS)

1 HCFA_PRVDR_SPCLTY_TB

- 50 = NURSE PRACTITIONER
- 51 = MEDICAL SUPPLY COMPANY WITH
CERTIFIED ORTHOTIST (CERTIFIED BY
AMERICAN BOARD FOR CERTIFICATION IN
PROSTHETICS AND ORTHOTICS)
- 52 = MEDICAL SUPPLY COMPANY WITH
CERTIFIED PROSTHETIST
(CERTIFIED BY AMERICAN BOARD FOR
CERTIFICATION IN PROSTHETICS AND
ORTHOTICS)
- 53 = MEDICAL SUPPLY COMPANY WITH
CERTIFIED PROSTHETIST-ORTHOTIST
(CERTIFIED BY AMERICAN BOARD FOR
CERTIFICATION IN PROSTHETICS
AND ORTHOTICS)
- 54 = MEDICAL SUPPLY COMPANY NOT INCLUDED
IN 51, 52, OR 53. (REVISED 10/93
TO MEAN MEDICAL SUPPLY COMPANY FOR DMERC)
- 55 = INDIVIDUAL CERTIFIED ORTHOTIST
- 56 = INDIVIDUAL CERTIFIED PROSTHETIST
- 57 = INDIVIDUAL CERTIFIED PROSTHETIST-
ORTHOTIST
- 58 = INDIVIDUALS NOT INCLUDED IN 55, 56,
OR 57 (REVISED 10/93 TO MEAN MEDICAL
SUPPLY COMPANY WITH REGISTERED
PHARMACIST)
- 59 = AMBULANCE SERVICE SUPPLIER, E.G.,
PRIVATE AMBULANCE COMPANIES, FUNERAL
HOMES, ETC.
- 60 = PUBLIC HEALTH OR WELFARE AGENCIES
(FEDERAL, STATE, AND LOCAL)
- 61 = VOLUNTARY HEALTH OR CHARITABLE
AGENCIES (E.G., NATIONAL CANCER
SOCIETY, NATIONAL HEART ASSOCIATION,
CATHOLIC CHARITIES)
- 62 = PSYCHOLOGIST (BILLING INDEPENDENTLY)
- 63 = PORTABLE X-RAY SUPPLIER
- 64 = AUDIOLOGIST (BILLING INDEPENDENTLY)
- 65 = PHYSICAL THERAPIST (INDEPENDENTLY
PRACTICING)
- 66 = RHEUMATOLOGY (EFF 5/92)
NOTE: DURING 93/94 DMERC ALSO USED THIS
TO MEAN MEDICAL SUPPLY COMPANY WITH
RESPIRATORY THERAPIST

1 HCFA_PRVDR_SPCLTY_TB

67 = OCCUPATIONAL THERAPIST (INDEPENDENTLY
PRACTICING)
68 = CLINICAL PSYCHOLOGIST
69 = CLINICAL LABORATORY (BILLING
INDEPENDENTLY)
70 = MULTISPECIALTY CLINIC OR GROUP
PRACTICE
71 = DIAGNOSTIC X-RAY (GPPP) (NOT TO
BE ASSIGNED AFTER 5/92)
HCFA PROVIDER SPECIALTY TABLE

72 = DIAGNOSTIC LABORATORY (GPPP)
(NOT TO BE ASSIGNED AFTER 5/92)
73 = PHYSIOTHERAPY (GPPP) (NOT TO BE
ASSIGNED AFTER 5/92)
74 = OCCUPATIONAL THERAPY (GPPP)
(NOT TO BE ASSIGNED AFTER 5/92)
75 = OTHER MEDICAL CARE (GPPP) (NOT TO
ASSIGNED AFTER 5/92)
76 = PERIPHERAL VASCULAR DISEASE
(EFF 5/92)
77 = VASCULAR SURGERY (EFF 5/92)
78 = CARDIAC SURGERY (EFF 5/92)
79 = ADDICTION MEDICINE (EFF 5/92)
80 = LICENSED CLINICAL SOCIAL WORKER
81 = CRITICAL CARE (INTENSIVISTS)
(EFF 5/92)
82 = HEMATOLOGY (EFF 5/92)
83 = HEMATOLOGY/ONCOLOGY (EFF 5/92)
84 = PREVENTIVE MEDICINE (EFF 5/92)
85 = MAXILLOFACIAL SURGERY (EFF 5/92)
86 = NEUROPSYCHIATRY (EFF 5/92)
87 = ALL OTHER SUPPLIERS (E.G. DRUG AND
DEPARTMENT STORES) (NOTE: DMERC USED
87 TO MEAN DEPARTMENT STORE FROM 10/93
THROUGH 9/94; RECODED EFF 10/94 TO A7;
NCH CROSS-WALKED DMERC REPORTED 87 TO A7.
88 = UNKNOWN SUPPLIER/PROVIDER SPECIALTY
(NOTE: DMERC USED 87 TO MEAN GROCERY
STORE FROM 10/93 - 9/94; RECODED EFF
10/94 TO A8; NCH CROSS-WALKED DMERC
REPORTED 88 TO A8.
89 = CERTIFIED CLINICAL NURSE SPECIALIST

90 = MEDICAL ONCOLOGY (EFF 5/92)
91 = SURGICAL ONCOLOGY (EFF 5/92)
92 = RADIATION ONCOLOGY (EFF 5/92)
93 = EMERGENCY MEDICINE (EFF 5/92)
94 = INTERVENTIONAL RADIOLOGY (EFF 5/92)
95 = INDEPENDENT PHYSIOLOGICAL
LABORATORY (EFF 5/92)
96 = OPTICIAN (EFF 10/93)
97 = PHYSICIAN ASSISTANT (EFF 5/92)
98 = GYNECOLOGIST/ONCOLOGIST (EFF 10/94)
99 = UNKNOWN PHYSICIAN SPECIALTY
A0 = HOSPITAL (EFF 10/93) (DMERCS ONLY)
A1 = SNF (EFF 10/93) (DMERCS ONLY)
A2 = INTERMEDIATE CARE NURSING FACILITY
(EFF 10/93) (DMERCS ONLY)
A3 = NURSING FACILITY, OTHER (EFF 10/93)
(DMERCS ONLY)
A4 = HHA (EFF 10/93) (DMERCS ONLY)
A5 = PHARMACY (EFF 10/93) (DMERCS ONLY)
A6 = MEDICAL SUPPLY COMPANY WITH RESPIRATORY
THERAPIST (EFF 10/93) (DMERCS ONLY)
A7 = DEPARTMENT STORE (FOR DMERC USE:
EFF 10/94, BUT CROSS-WALKED FROM
CODE 87 EFF 10/93)
A8 = GROCERY STORE (FOR DMERC USE:
EFF 10/94, BUT CROSS-WALKED FROM
CODE 88 EFF 10/93)

1 HCFA_PRVDR_SPCLTY_TB

HCFA PROVIDER SPECIALTY TABLE

1 HCFA_TYPE_SRVC_TB

HCFA TYPE OF SERVICE TABLE

1 = MEDICAL CARE
2 = SURGERY
3 = CONSULTATION
4 = DIAGNOSTIC RADIOLOGY
5 = DIAGNOSTIC LABORATORY
6 = THERAPEUTIC RADIOLOGY
7 = ANESTHESIA
8 = ASSISTANT AT SURGERY
9 = OTHER MEDICAL ITEMS OR SERVICES

O = WHOLE BLOOD ONLY EFF 01/96,
WHOLE BLOOD OR PACKED RED CELLS BEFORE 01/96
A = USED DURABLE MEDICAL EQUIPMENT (DME)
B = HIGH RISK SCREENING MAMMOGRAPHY
(OBSOLETE 1/1/98)
C = LOW RISK SCREENING MAMMOGRAPHY
(OBSOLETE 1/1/98)
D = AMBULANCE (EFF 04/95)
E = ENTERAL/PARENTERAL NUTRIENTS/SUPPLIES
(EFF 04/95)
F = AMBULATORY SURGICAL CENTER (FACILITY
USAGE FOR SURGICAL SERVICES)
G = IMMUNOSUPPRESSIVE DRUGS
H = HOSPICE SERVICES (DISCONTINUED 01/95)
I = PURCHASE OF DME (INSTALLMENT BASIS)
(DISCONTINUED 04/95)
J = DIABETIC SHOES (EFF 04/95)
K = HEARING ITEMS AND SERVICES (EFF 04/95)
L = ESRD SUPPLIES (EFF 04/95)
(RENAL SUPPLIER IN THE HOME BEFORE 04/95)
M = MONTHLY CAPITATION PAYMENT FOR DIALYSIS
N = KIDNEY DONOR
P = LUMP SUM PURCHASE OF DME, PROSTHETICS,
ORTHOTICS
Q = VISION ITEMS OR SERVICES
R = RENTAL OF DME
S = SURGICAL DRESSINGS OR OTHER MEDICAL SUPPLIES
(EFF 04/95)
T = PSYCHOLOGICAL THERAPY (TERM. 12/31/97)
OUTPATIENT MENTAL HEALTH LIMITATION (EFF. 1/1/98)
U = OCCUPATIONAL THERAPY
V = PNEUMOCOCCAL/FLU VACCINE (EFF 01/96),
PNEUMOCOCCAL/FLU/HEPATITIS B VACCINE (EFF 04/95-12/95),
PNEUMOCOCCAL ONLY BEFORE 04/95
W = PHYSICAL THERAPY
Y = SECOND OPINION ON ELECTIVE SURGERY
(OBSOLETED 1/97)
Z = THIRD OPINION ON ELECTIVE SURGERY
(OBSOLETED 1/97)

1 LINE_ADDTNL_CLM_DCMTN_IND_TB

LINE ADDITIONAL CLAIM DOCUMENTATION INDICATOR TABLE

0 = NO ADDITIONAL DOCUMENTATION
1 = ADDITIONAL DOCUMENTATION SUBMITTED FOR
NON-DME EMC CLAIM
2 = CMN/PRESCRIPTION/OTHER DOCUMENTATION SUBMITTED
WHICH JUSTIFIES MEDICAL NECESSITY
3 = PRIOR AUTHORIZATION OBTAINED AND APPROVED
4 = PRIOR AUTHORIZATION REQUESTED BUT NOT APPROVED
5 = CMN/PRESCRIPTION/OTHER DOCUMENTATION SUBMITTED
BUT DID NOT JUSTIFY MEDICAL NECESSITY
6 = CMN/PRESCRIPTION/OTHER DOCUMENTATION SUBMITTED
AND APPROVED AFTER PRIOR AUTHORIZATION REJECTED
7 = RECERTIFICATION CMN/PRESCRIPTION/OTHER
DOCUMENTATION

1 LINE_PLC_SRVC_TB

LINE PLACE OF SERVICE TABLE

PRIOR TO 1/92

1 = OFFICE
2 = HOME
3 = INPATIENT HOSPITAL
4 = SNF
5 = OUTPATIENT HOSPITAL
6 = INDEPENDENT LAB
7 = OTHER
8 = INDEPENDENT KIDNEY DISEASE TREATMENT
CENTER
9 = AMBULATORY
A = AMBULANCE SERVICE
H = HOSPICE
M = MENTAL HEALTH, RURAL MENTAL HEALTH
N = NURSING HOME
R = RURAL CODES

EFFECTIVE 1/92

11 = OFFICE
12 = HOME
21 = INPATIENT HOSPITAL
22 = OUTPATIENT HOSPITAL
23 = EMERGENCY ROOM - HOSPITAL

24 = AMBULATORY SURGICAL CENTER
25 = BIRTHING CENTER
26 = MILITARY TREATMENT FACILITY
31 = SKILLED NURSING FACILITY
32 = NURSING FACILITY
33 = CUSTODIAL CARE FACILITY
34 = HOSPICE
35 = ADULT LIVING CARE FACILITIES (ALCF)
(EFF. NYD - ADDED 12/3/97)
41 = AMBULANCE - LAND
42 = AMBULANCE - AIR OR WATER
50 = FEDERALLY QUALIFIED HEALTH CENTERS
(EFF. 10/1/93)
51 = INPATIENT PSYCHIATRIC FACILITY
52 = PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53 = COMMUNITY MENTAL HEALTH CENTER
54 = INTERMEDIATE CARE FACILITY/MENTALLY
RETARDED
55 = RESIDENTIAL SUBSTANCE ABUSE TREATMENT
FACILITY
56 = PSYCHIATRIC RESIDENTIAL TREATMENT
CENTER
60 = MASS IMMUNIZATIONS CENTER (EFF. 9/1/97)
61 = COMPREHENSIVE INPATIENT REHABILITATION
FACILITY
62 = COMPREHENSIVE OUTPATIENT REHABILITATION
FACILITY
65 = END STAGE RENAL DISEASE TREATMENT FACILITY
71 = STATE OR LOCAL PUBLIC HEALTH CLINIC
72 = RURAL HEALTH CLINIC
81 = INDEPENDENT LABORATORY

1 LINE_PLC_SRVC_TB

LINE PLACE OF SERVICE TABLE

99 = OTHER UNLISTED FACILITY

1 LINE_PMT_IND_TB

LINE PAYMENT INDICATOR TABLE

1 = ACTUAL CHARGE
2 = CUSTOMARY CHARGE
3 = PREVAILING CHARGE (ADJUSTED, UNADJUSTED
GAP FILL, ETC)

1	LINE_PRCSG_IND_TB	LINE PROCESSING INDICATOR TABLE
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1	LINE	PRVDR	PRTCPTG	IND	TB	LINE	PROVIDER	PARTICIPATING	INDICATOR	TABLE
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1 = PARTICIPATING
2 = ALL OR SOME COVERED AND ALLOWED
EXPENSES APPLIED TO DEDUCTIBLE PARTICIPATING
3 = ASSIGNMENT ACCEPTED/NON-PARTICIPATING
4 = ASSIGNMENT NOT ACCEPTED/NON-PARTICIPATING
5 = ASSIGNMENT ACCEPTED BUT ALL OR SOME
COVERED AND ALLOWED EXPENSES APPLIED
TO DEDUCTIBLE NON-PARTICIPATING.
6 = ASSIGNMENT NOT ACCEPTED AND ALL COVERED
AND ALLOWED EXPENSES APPLIED TO DEDUCTIBLE
NON-PARTICIPATING.
7 = PARTICIPATING PROVIDER NOT ACCEPTING
ASSIGNMENT.

1 NCH_CLM_TYPE_TB

NCH CLAIM TYPE TABLE

10 = HHA CLAIM
20 = NON SWING BED SNF CLAIM
30 = SWING BED SNF CLAIM
40 = OUTPATIENT CLAIM
41 = OUTPATIENT 'FULL-ENCOUNTER' CLAIM
(AVAILABLE IN NMUD)
42 = OUTPATIENT 'ABBREVIATED-ENCOUNTER' CLAIM
(AVAILABLE IN NMUD)
50 = HOSPICE CLAIM
60 = INPATIENT CLAIM
61 = INPATIENT 'FULL-ENCOUNTER' CLAIM
62 = INPATIENT 'ABBREVIATED-ENCOUNTER CLAIM
(AVAILABLE IN NMUD)
71 = RIC O LOCAL CARRIER NON-DMEPOS CLAIM
72 = RIC O LOCAL CARRIER DMEPOS CLAIM
73 = PHYSICIAN 'FULL-ENCOUNTER' CLAIM
(AVAILABLE IN NMUD)
81 = RIC M DMERC NON-DMEPOS CLAIM
82 = RIC M DMERC DMEPOS CLAIM

1 NCH_EDIT_TB

NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > \$100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A1X1 = (C) PERCENT ALLOWED INDICATOR
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>\$7,500
Y011 = (C) INP CLAIM/REIM > \$75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > \$150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150

1 NCH_EDIT_TB

Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER

NCH EDIT TABLE

0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME HCPCS
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE

13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

NCH EDIT TABLE

2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN

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NCH_EDIT_TB

2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624

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NCH_EDIT_TB

3720 = (C) IDE AND LINE ITEM NUMBER > 2
 3801 = (C) AMT BENE PD INVALID
 4001 = (C) BLOOD PINTS FURNISHED INVALID
 4002 = (C) BLOOD FURNISHED/REPLACED INVALID

NCH EDIT TABLE

4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
 4201 = (C) BLOOD PINTS UNREPLACED INVALID
 4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
 4203 = (C) INVALID CPO PROVIDER NUMBER
 4301 = (C) BLOOD DEDUCTABLE INVALID
 4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
 4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
 4304 = (C) BLOOD DEDUCT > 3 - REPLACED
 4501 = (C) PRIMARY DIAGNOSIS INVALID
 46XA = (C) MSP VET AND VET AT MEDICARE
 46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
 46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
 46XG = (C) VALU CODE 20 INVALID
 46XN = (C) VALUE CODE 37,38,39 INVALID
 46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
 46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
 46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
 46XR = (C) BLD FIELDS VS REV CDE 380,381,382
 46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
 46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
 46X1 = (C) VALUE AMOUNT INVALID
 46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
 46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
 46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
 46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
 46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
 46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
 46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
 46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
 4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
 4601 = (C) CABG/PCOE, MSP CODE PRESENT
 4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
 4901 = (C) PCOE/CABG,DEN CD NOT D
 4902 = (C) PCOE/CABG BUT DME
 50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
 50X2 = (C) REV CD=054X,MOD NOT = QM,QN
 5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS

5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK

NCH EDIT TABLE

51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR

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5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
524Z = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR

NCH EDIT TABLE

5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY

1 NCH_EDIT_TB

5378 = (C) SERVICE DATE < AGE 50
5399 = (U) HOSPICE PERIOD NUM MATCH
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > \$150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS

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NCH_EDIT_TB

59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID

NCH EDIT TABLE

6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK

65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HPCPS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.

NCH EDIT TABLE

69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME

1 NCH_EDIT_TB

6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78X1 = (C) THRU DATE INVALID
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING

1

NCH_EDIT_TB

8031 = (U) HH PT A REMAINING > 0
NCH EDIT TABLE

8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID, UNITS, ENT, ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID

93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID

NCH EDIT TABLE

94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE, INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE

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NCH_EDIT_TB

96X1 = (C) OTHER AMOUNTS INVALID
 96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
 97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
 97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
 98X1 = (C) COINSURANCE INVALID
 98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
 98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
 98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
 99XX = (D) POSS DUPE, PART B DOC-ID
 9901 = (C) REV CODE INVALID OR TRAILER CNT=0
 9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
 9903 = (C) NO CLINIC VISITS FOR RHC
 9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
 991X = (C) NO DATE OF SERVICE
 9910 = (C) EDIT 9910 (NEW)
 9911 = (C) BLOOD VERIFIED INVALID
 9920 = (C) EDIT 9920 (NEW)
 9930 = (C) EDIT 9930 (NEW)
 9931 = (C) OUTPAT COINSURANCE VALUES
 9933 = (C) RATE EXCEEDS MAMMOGRAPHY LIMIT
 9940 = (C) EDIT 9940 (NEW)
 9942 = (C) EDIT 9942 (NEW)
 9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
 9945 = (C) SERVICE DATE < 98001
 9946 = (C) INVALID DIAGNOSIS CODE
 9947 = (C) INVALID DIAGNOSIS CODE
 9948 = (C) STAY FROM>96365,DIAG=V725
 9960 = (C) MED CHOICE BUT HMO DATA MISSING
 9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
 9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

1 NCH_IP_PRO_APRVL_TYPE_TB

NCH INPATIENT PEER REVIEW ORGANIZATION APPROVAL TYPE TABLE

- 1 = APPROVED BY THE PRO AS BILLED - CODE
 INDICATES THAT THE CLAIM HAS BEEN
 REVIEWED BY THE PRO AND HAS BEEN FULLY
 APPROVED INCLUDING ANY DAY OR COST
 OUTLIERS.
 2 = AUTOMATIC APPROVAL - DOES NOT APPLY TO
 MEDICARE CLAIM.
 3 = PARTIAL APPROVAL - CODE INDICATES THE
 BILL HAS BEEN REVIEWED BY THE PRO, AND

SOME PORTION (DAYS OR SERVICES) HAS BEEN DENIED. THE FROM/THRU DATES OF THE APPROVED PORTION OF THE STAY, EXCLUDING GRACE DAYS AND ANY PERIOD AT A NONCOVERED LEVEL OF CARE ARE SHOWN ON THE BILL.

- 4 = ADMISSION DENIED - CODE INDICATES THE PATIENT'S NEED FOR INPATIENT SERVICES WAS REVIEWED UPON ADMISSION AND THE PRO FOUND THAT THE STAY WAS NOT MEDICALLY NECESSARY.
- 5 = POST PAYMENT REVIEW - CODE INDICATES THAT ANY MEDICAL REVIEW WILL BE COMPLETED AFTER THE CLAIM IS PAID. THE BILL MAY BE A DAY OUTLIER, PART OF THE SAMPLE REVIEW, OR MAY NOT BE REVIEWED.
- 6 = PRE-ADMISSION AUTHORIZATION - PRE-ADMISSION AUTHORIZATION OBTAINED, BUT SERVICES NOT REVIEWED BY THE PRO.
- 7 THRU 9 = RESERVED.

1 NCH_NEAR_LINE_RIC_TB

NCH NEAR-LINE RECORD IDENTIFICATION CODE TABLE

- O = PART B PHYSICIAN/SUPPLIER CLAIM RECORD (PROCESSED BY LOCAL CARRIERS; CAN INCLUDE DMEPOS SERVICES)
- V = PART A INSTITUTIONAL CLAIM RECORD (INPATIENT (IP), SKILLED NURSING FACILITY (SNF), CHRISTIAN SCIENCE (CS), HOME HEALTH AGENCY (HHA), OR HOSPICE)
- W = PART B INSTITUTIONAL CLAIM RECORD (OUTPATIENT (OP), HHA)
- U = BOTH PART A AND B INSTITUTIONAL HOME HEALTH AGENCY (HHA) CLAIM RECORDS -- DUE TO HHPPS AND HHA A/B SPLIT. (EFFECTIVE 10/00)
- M = PART B DMEPOS CLAIM RECORD (PROCESSED BY DME REGIONAL CARRIER) (EFFECTIVE 10/93)

1 NCH_PATCH_TB

NCH PATCH TABLE

-
-
- 01 = RRB CATEGORY EQUATABLE BIC - CHANGED (ALL CLAIM TYPES) -- APPLIED DURING THE NEARLINE 'G' CONVERSION TO CLAIMS WITH NCH WEEKLY PROCESS DATE BEFORE 3/91. PRIOR TO VERSION 'H', PATCH INDICATOR STORED IN REDEFINED CLAIM EDIT GROUP, 3RD OCCURRENCE, POSITION 2.
 - 02 = CLAIM TRANSACTION CODE MADE CONSISTENT WITH NCH PAYMENT/EDIT RIC CODE (OP AND HHA) -- EFFECTIVE 3/94, CWFMQA BEGAN PATCH. DURING 'H' CONVERSION, PATCH APPLIED TO CLAIMS WITH NCH WEEKLY PROCESS DATE PRIOR TO 3/94. PRIOR TO VERSION 'H', PATCH INDICATOR STORED IN REDEFINED CLAIM EDIT GROUP, 4TH OCCURRENCE, POSITION 1.
 - 03 = GARBAGE/NONNUMERIC CLAIM TOTAL CHARGE AMOUNT SET TO ZEROES (INSTNL) -- DURING THE VERSION 'G' CONVERSION, ERROR OCCURRED IN THE DERIVATION OF THIS FIELD WHERE THE CLAIM WAS MISSING REVENUE CENTER CODE = '0001'. IN 1994, PATCH WAS APPLIED TO THE OP AND HHA SAFS ONLY. (THIS SAF PATCH INDICATOR WAS STORED IN THE REDEFINED CLAIM EDIT GROUP, 4TH OCCURRENCE, POSITION 2). DURING THE 'H' CONVERSION, PATCH APPLIED TO NEARLINE CLAIMS WHERE GARBAGE OR NONNUMERIC VALUES.
 - 04 = INCORRECT BENE RESIDENCE SSA STANDARD COUNTY CODE '999' CHANGED (ALL CLAIM TYPES) -- APPLIED DURING THE NEARLINE 'G' CONVERSION AND ONGOING THROUGH 4/21/94, CALLING EQSTZIP ROUTINE TO CLAIMS WITH NCH WEEKLY PROCESS DATE PRIOR TO 4/22/94. PRIOR TO VERSION 'H' PATCH INDICATOR STORED IN REDEFINED CLAIM EDIT GROUP, 3RD OCCURRENCE, POSITION 4.
 - 05 = WRONG CENTURY BENE BIRTH DATE CORRECTED (ALL CLAIM TYPES) -- APPLIED DURING NEARLINE 'H' CONVERSION TO ALL HISTORY WHERE CENTURY GREATER THAN 1700 AND LESS THAN 1850; IF CENTURY LESS THAN 1700, ZEROES MOVED.
 - 06 = INCONSISTENT CWF BENE MEDICARE STATUS CODE MADE CONSISTENT WITH AGE (ALL CLAIM TYPES) -- APPLIED DURING NEARLINE 'H' CONVERSION TO ALL

HISTORY AND PATCHED ONGOING. BENE AGE IS
CALCULATED TO DETERMINE THE CORRECT VALUE;
IF GREATER THAN 64, 1ST POSITION MSC ='1';
IF LESS THAN 65, 1ST POSITION MSC = '2'.
07 = MISSING CWF BENE MEDIARE STATUS CODE DERIVED
(ALL CLAIM TYPES) -- APPLIED DURING NEARLINE
'H' CONVERSION TO ALL HISTORY AND PATCHED
ONGOING, EXCEPT CLAIMS WITH UNKNOWN DOB AND/
OR CLAIM FROM DATE='0' (LEFT BLANK). BENE
AGE IS CALCULATED TO DETERMINE MISSING VALUE;
IF GREATER THAN 64, MSC='10'; IF LESS THAN
65, MSC = '20'.
08 = INVALID NCH PRIMARY PAYER CODE SET TO BLANKS
(INSTNL) -- APPLIED DURING VERSION 'H' CON-
VERSION TO CLAIMS WITH NCH WEEKLY PROCESS
DATE 10/1/93-10/30/95, WHERE MSP VALUES =
NCH PATCH TABLE

1 NCH_PATCH_TB

INVALID '0', '1', '2', '3' OR '4' (CAUSED
BY ERRONEOUS LOGIC IN HCFA PROGRAM CODE,
WHICH WAS CORRECTED ON 11/1/95).
09 = ZERO CWF CLAIM ACCRETION DATE REPLACED WITH
NCH WEEKLY PROCESS DATE (ALL CLAIM TYPES)
-- APPLIED DURING VERSION 'H' CONVERSION TO
INSTNL AND DMERC CLAIMS; APPLIED DURING
VERSION 'G' CONVERSION TO NON-INSTITUTIONAL
(NON-DMERC) CLAIMS. PRIOR TO VERSION 'H',
PATCH INDICATOR STORED IN REDEFINED CLAIM
EDIT GROUP, 3RD OCCURRENCE, POSITION 1.
10 = MULTIPLE REVENUE CENTER 0001 (OUTPATIENT,
HHA AND HOSPICE) -- PATCH APPLIED TO 1998 &
1999 NEARLINE AND SAFS TO DELETE ANY REVENUE
CODES THAT FOLLOWED THE FIRST '0001' REVENUE
CENTER CODE. THE EDIT WAS APPLIED ACROSS ALL
INSTITUTIONAL CLAIM TYPES, INCLUDING INPATIENT/
SNF (THE PROBLEM WAS ONLY FOUND WITH OP/HHA/
HOSPICE CLAIMS). THE PROBLEM WAS CORRECTED
6/25/99.
11 = TRUNCATED CLAIM TOTAL CHARGE AMOUNT IN THE
FIXED PORTION REPLACED WITH THE TOTAL CHARGE
AMOUNT IN THE REVENUE CENTER 0001 AMOUNT FIELD
-- SERVICE YEARS 1998 & 1999 PATCHED DURING
QUARTERLY MERGE. THE 1998 & 1999 SAFS WERE

CORRECTED WHEN FINALIZED IN 7/99. THE PATCH WAS DONE FOR RECORDS WITH NCH DAILY PROCESS DATE 1/4/99 - 5/14/99.

- 12 = MISSING CLAIM-LEVEL HHA TOTAL VISIT COUNT -- SERVICE YEARS 1998, 1999 & 2000 PATCH APPLIED DURING VERSION 'I' CONVERSION OF BOTH THE NEARLINE AND SAFS. PROBLEM OCCURS IN THOSE CLAIMS RECOVERED DURING THE MISSING CLAIMS EFFORT.
- 13 = INCONSISTENT CLAIM MCO PAID SWITCH MADE CONSISTENT WITH CRITERIA USED TO IDENTIFY AN INPATIENT ENCOUNTER CLAIM -- IF MCO PAID SWITCH EQUAL TO BLANK OR '0' AND ALL CONDITIONS ARE MET TO INDICATE AN INPATIENT ENCOUNTER CLAIM (BENE ENROLLED IN A RISK MCO DURING THE SERVICE PERIOD), CHANGE THE SWITCH TO A '1'. THE PATCH WAS APPLIED DURING THE VERSION 'I' CONVERSION, FOR CLAIMS BACK TO 7/1/97 SERVICE THRU DATE.

1 NCH_STATE_SGMT_TB

NCH STATE SEGMENT TABLE

- 01 = ALABAMA
 02 = ALASKA
 03 = ARIZONA
 04 = ARKANSAS
 05 = CALIFORNIA
 06 = COLORADO
 07 = CONNECTICUT
 08 = DELAWARE
 09 = DISTRICT OF COLUMBIA
 10 = FLORIDA
 11 = GEORGIA
 12 = HAWAII
 13 = IDAHO
 14 = ILLINOIS
 15 = INDIANA
 16 = IOWA
 17 = KANSAS
 18 = KENTUCKY
 19 = LOUISIANA
 20 = MAINE
 21 = MARYLAND
 22 = MASSACHUSETTS

23 = MICHIGAN
24 = MINNESOTA
25 = MISSISSIPPI
26 = MISSOURI
27 = MONTANA
28 = NEBRASKA
29 = NEVADA
30 = NEW HAMPSHIRE
31 = NEW JERSEY
32 = NEW MEXICO
33 = NEW YORK
34 = NORTH CAROLINA
35 = NORTH DAKOTA
36 = OHIO
37 = OKLAHOMA
38 = OREGON
39 = PENNSYLVANIA
40 = PUERTO RICO
41 = RHODE ISLAND
42 = SOUTH CAROLINA
43 = SOUTH DAKOTA
44 = TENNESEE
45 = TEXAS
46 = UTAH
47 = VERMONT
48 = VIRGIN ISLANDS
49 = VIRGINIA
50 = WASHINGTON
51 = WEST VIRGINIA
52 = WISCONSIN
53 = WYOMING
54 = AFRICA
55 = ASIA
56 = CANADA
57 = CENTRAL AMERICA & WEST INDIES
58 = EUROPE
59 = MEXICO
60 = OCEANIA
61 = PHILIPPINES
62 = SOUTH AMERICA
63 = US POSSESSIONS

1 NCH_STATE_SGMT_TB

NCH STATE SEGMENT TABLE

97 = SAIPAN - MP
 98 = GUAM
 99 = AMERICAN SAMOA

1 PRVDR_NUM_TB

PROVIDER NUMBER TABLE

- FIRST TWO POSITIONS ARE THE GEO SSA STATE CODE.
 EXCEPTION: 55 = CALIFORNIA
 67 = TEXAS
 68 = FLORIDA

- POSITIONS 3 AND SOMETIMES 4 ARE USED AS A
 CATEGORY IDENTIFIER. THE REMAINING POSITIONS
 ARE SERIAL NUMBERS. THE FOLLOWING BLOCKS OF NUMBERS
 ARE RESERVED FOR THE FACILITIES INDICATED (NOTE:
 MAY HAVE DIFFERENT MEANINGS DEPENDENT ON THE TYPE
 OF BILL (TOB) :

0001-0879	SHORT-TERM (GENERAL AND SPECIALTY) HOSPITALS WHERE TOB = 11X; ESRD CLINIC WHERE TOB = 72X
0880-0899	RESERVED FOR HOSPITALS PARTICIPATING IN ORD DEMONSTRATION PROJECTS WHERE TOB = 11X; ESRD CLINIC WHERE TOB = 72X
0900-0999	MULTIPLE HOSPITAL COMPONENT IN A MEDICAL COMPLEX (NUMBERS RETIRED) WHERE TOB = 11X; ESRD CLINIC WHERE TOB = 72X
1000-1199	RESERVED FOR FUTURE USE
1200-1224	ALCOHOL/DRUG HOSPITALS (EXCLUDED FROM PPS-NUMBERS RETIRED) WHERE TOB = 11X; ESRD CLINIC WHERE TOB = 72X
1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT); ESRD CLINIC WHERE TOB = 72X
1300-1399	RURAL PRIMARY CARE HOSPITAL (RCPH) - EFF. 10/97 CHANGED TO CRITICAL ACCESS HOSPITALS (CAH)
1400-1499	CONTINUATION OF 4900-4999 SERIES (CMHC)
1500-1799	HOSPICES

1 PRVDR_NUM_TB

1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) WHERE TOB = 73X; SNF (IP PTB) WHERE TOB = 22X; HHA WHERE TOB = 32X, 33X, 34X
1990-1999	CHRISTIAN SCIENCE SANATORIA (HOSPITAL SERVICES)
2000-2299	LONG-TERM HOSPITALS (EXCLUDED FROM PPS)
2300-2499	CHRONIC RENAL DISEASE FACILITIES (HOSPITAL BASED)
2500-2899	NON-HOSPITAL RENAL DISEASE TREATMENT CENTERS
2900-2999	INDEPENDENT SPECIAL PURPOSE RENAL DIALYSIS FACILITY (1)
3000-3024	FORMERLY TUBERCULOSIS HOSPITALS (NUMBERS RETIRED)
3025-3099	REHABILITATION HOSPITALS (EXCLUDED FROM PPS)
3100-3199	CONTINUATION OF SUBUNITS OF NONPROFIT AND PROPRIETARY HOME HEALTH AGENCIES (7300-7399) SERIES (3) (EFF. 4/96)
3200-3299	CONTINUATION OF 4800-4899 SERIES (CORF) PROVIDER NUMBER TABLE -----
3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS) WHERE TOB = 11X; ESRD CLINIC WHERE TOB = 72X
3400-3499	CONTINUATION OF RURAL HEALTH CLINICS (PROVIDER-BASED) (3975-3999)
3500-3699	RENAL DISEASE TREATMENT CENTERS (HOSPITAL SATELLITES)
3700-3799	HOSPITAL BASED SPECIAL PURPOSE RENAL DIALYSIS FACILITY (1)
3800-3974	RURAL HEALTH CLINICS (FREE-STANDING)
3975-3999	RURAL HEALTH CLINICS (PROVIDER-BASED)
4000-4499	PSYCHIATRIC HOSPITALS (EXCLUDED FROM PPS)
4500-4599	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC); 9/30/91 - 3/31/97 USED FOR CLINIC OPT WHERE TOB = 74X
4800-4899	CONTINUATION OF 4500-4599 SERIES (CORF) (EFF. 10/95)

4900-4999 CONTINUATION OF 4600-4799 SERIES (CMHC)
(EFF. 10/95); 9/30/91 - 3/31/97 USED FOR
CLINIC OPT WHERE TOB = 74X
5000-6499 SKILLED NURSING FACILITIES
6500-6989 CMHC / OUTPATIENT PHYSICAL THERAPY SERVICES
WHERE TOB = 74X; CORF WHERE TOB =
75X
6990-6999 CHRISTIAN SCIENCE SANATORIA (SKILLED
NURSING SERVICES)
7000-7299 HOME HEALTH AGENCIES (HHA) (2)
7300-7399 SUBUNITS OF 'NONPROFIT' AND
'PROPRIETARY' HOME HEALTH AGENCIES (3)
7400-7799 CONTINUATION OF 7000-7299 SERIES
7800-7999 SUBUNITS OF STATE AND LOCAL GOVERNMENTAL
HOME HEALTH AGENCIES (3)
8000-8499 CONTINUATION OF 7400-7799 SERIES (HHA)
8500-8899 CONTINUATION OF RURAL HEALTH
CENTER (PROVIDER BASED) (3400-3499)
8900-8999 CONTINUATION OF RURAL HEALTH
CENTER (FREE-STANDING) (3800-3974)
9000-9499 CONTINUATION OF 8000-8499 SERIES (HHA)
(EFF. 10/95)
9500-9999 RESERVED FOR FUTURE USE (EFF. 8/1/98)
NOTE: 10/95-7/98 THIS SERIES WAS
ASSIGNED TO HHA'S BUT RESCINDED - NO
HHA'S WERE EVER ASSIGNED A NUMBER
FROM THIS SERIES.

EXCEPTION:

P001-P999 ORGAN PROCUREMENT ORGANIZATION

- (1) THESE FACILITIES (SPRDFS) WILL BE ASSIGNED
THE SAME PROVIDER NUMBER WHENEVER THEY
ARE RECERTIFIED.
- (2) THE 6400-6499 SERIES OF PROVIDER NUMBERS
IN IOWA (16), SOUTH DAKOTA (43) AND TEXAS (45)
PROVIDER NUMBER TABLE

1 PRVDR_NUM_TB

HAVE BEEN USED IN REDUCING ACUTE CARE COSTS (RACC)
EXPERIMENTS.

(3) IN VIRGINIA (49), THE SERIES 7100-7299 HAS BEEN RESERVED FOR STATEWIDE SUBUNIT COMPONENTS OF THE VIRGINIA STATE HOME HEALTH AGENCIES.

(4) PARENT AGENCY MUST HAVE A NUMBER IN THE 7000-7299, 7400-7799 OR 8000-8499 SERIES.

NOTE:

THERE IS A SPECIAL NUMBERING SYSTEM FOR UNITS OF HOSPITALS THAT ARE EXCLUDED FROM PROSPECTIVE PAYMENT SYSTEM (PPS) AND HOSPITALS WITH SNF SWING-BED DESIGNATION. AN ALPHA CHARACTER IN THE THIRD POSITION OF THE PROVIDER NUMBER IDENTIFIES THE TYPE OF UNIT OR SWING-BED DESIGNATION AS FOLLOWS:

S = PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
 T = REHABILITATION UNIT (EXCLUDED FROM PPS)
 U = SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
 V = ALCOHOL DRUG UNIT (PRIOR TO 10/87 ONLY)
 W = LONG TERM SNF SWING-BED HOSPITAL
 (EFF 3/91)
 Y = REHAB HOSPITAL SWING-BED (EFF 9/92)
 Z = RURAL PRIMARY CARE SWING-BED HOSPITAL

THERE IS ALSO A SPECIAL NUMBERING SYSTEM FOR ASSIGNING EMERGENCY HOSPITAL IDENTIFICATION NUMBERS (NON PARTICIPATING HOSPITALS). THE SIXTH POSITION OF THE PROVIDER NUMBER IS AS FOLLOWS:

E = NON-FEDERAL EMERGENCY HOSPITAL
 F = FEDERAL EMERGENCY HOSPITAL

1 PTNT_DSCHRG_STUS_TB

PATIENT DISCHARGE STATUS TABLE

01 = DISCHARGED TO HOME/SELF CARE (ROUTINE CHARGE) .
 02 = DISCHARGED/TRANSFERRED TO OTHER SHORT TERM GENERAL HOSPITAL FOR INPATIENT CARE.
 03 = DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (SNF) - (FOR HOSPITALS

WITH AN APPROVED SWING BED ARRANGEMENT,
USE CODE 61 - SWING BED. FOR REPORTING
DISCHARGES/TRANSFERS TO A NON-CERTIFIED
SNF, THE HOSPITAL MUST USE CODE 04 - ICF.

04 = DISCHARGED/TRANSFERRED TO INTERMEDIATE
CARE FACILITY (ICF).

05 = DISCHARGED/TRANSFERRED TO ANOTHER TYPE
OF INSTITUTION FOR INPATIENT CARE (INCLUDING
DISTINCT PARTS).

06 = DISCHARGED/TRANSFERRED TO HOME CARE OF
ORGANIZED HOME HEALTH SERVICE ORGANIZATION.

07 = LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED
CARE.

08 = DISCHARGED/TRANSFERRED TO HOME UNDER
CARE OF A HOME IV DRUG THERAPY PROVIDER.

09 = ADMITTED AS AN INPATIENT TO THIS
HOSPITAL (EFFECTIVE 3/1/91). IN SITUA-
TIONS WHERE A PATIENT IS ADMITTED BEFORE
MIDNIGHT OF THE THIRD DAY FOLLOWING THE
DAY OF AN OUTPATIENT SERVICE, THE OUT-
PATIENT SERVICES ARE CONSIDERED INPATIENT.

20 = EXPIRED (DID NOT RECOVER - CHRISTIAN
SCIENCE PATIENT).

30 = STILL PATIENT.

40 = EXPIRED AT HOME (HOSPICE CLAIMS ONLY)

41 = EXPIRED IN A MEDICAL FACILITY SUCH AS
HOSPITAL, SNF, ICF, OR FREESTANDING
HOSPICE. (HOSPICE CLAIMS ONLY)

42 = EXPIRED - PLACE UNKNOWN (HOSPICE CLAIMS
ONLY)

50 = HOSPICE - HOME (EFF. 10/96)

51 = HOSPICE - MEDICAL FACILITY (EFF. 10/96)

61 = DISCHARGED/TRANSFERRED WITHIN THIS INSTI-
TUTION TO A HOSPITAL-BASED MEDICARE
APPROVED SWING BED (TO BE IMPLEMENTED IN
1999)

71 = DISCHARGED/TRANSFERRED/REFERRED TO ANOTHER
INSTITUTION FOR OUTPATIENT SERVICES AS
SPECIFIED BY THE DISCHARGE PLAN OF CARE (TO
BE IMPLEMENTED IN 1999).

72 = DISCHARGED/TRANSFERRED/REFERRED TO THIS
INSTITUTION FOR OUTPATIENT SERVICES AS
SPECIFIED BY THE DISCHARGE PLAN OF CARE
(TO BE IMPLEMENTED IN 1999).

1 REV_CNTR_ANSI_TB

REVENUE CENTER ANSI CODE TABLE

*****EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*****
*****POSITIONS 1 & 2 OF ANSI CODE*****

CO = CONTRACTUAL OBLIGATIONS -- THIS GROUP CODE SHOULD
BE USED WHEN A CONTRACTUAL AGREEMENT BETWEEN THE
PAYER AND PAYEE, OR A REGULATORY REQUIREMENT, RE-
SULTED IN AN ADJUSTMENT. GENERALLY, THESE ADJUST-
MENTS ARE CONSIDERED A WRITE-OFF FOR THE PROVIDER
AND ARE NOT BILLED TO THE PATIENT.

CR = CORRECTIONS AND REVERSALS -- THIS GROUP CODE SHOULD
BE USED FOR CORRECTING A PRIOR CLAIM. IT APPLIES
WHEN THERE IS A CHANGE TO A PREVIOUSLY ADJUDICATED
CLAIM.

OA = OTHER ADJUSTMENTS -- THIS GROUP CODE SHOULD BE USED
WHEN NO OTHER GROUP CODE APPLIES TO THE ADJUSTMENT.

PI = PAYER INITIATED REDUCTIONS -- THIS GROUP CODE SHOULD
BE USED WHEN, IN THE OPINION OF THE PAYER, THE ADJUST-
MENT IS NOT THE RESPONSIBILITY OF THE PATIENT, BUT
THERE IS NO SUPPORTING CONTRACT BETWEEN THE PROVIDER
AND THE PAYER (I.E., MEDICAL REVIEW OR PROFESSIONAL
REVIEW ORGANIZATION ADJUSTMENTS).

PR = PATIENT RESPONSIBILITY -- THIS GROUP SHOULD BE USED
WHEN THE ADJUSTMENT REPRESENTS AN AMOUNT THAT SHOULD
BE BILLED TO THE PATIENT OR INSURED. THIS GROUP
WOULD TYPICALLY BE USED FOR DEDUCTIBLE AND COPAY
ADJUSTMENTS.

*****CLAIM ADJUSTMENT REASON CODES*****
*****POSITIONS 3 THROUGH 5 OF ANSI CODE*****

1 = DEDUCTIBLE AMOUNT

2 = COINSURANCE AMOUNT

3 = CO-PAY AMOUNT

4 = THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER
USED OR A REQUIRED MODIFIER IS MISSING.

5 = THE PROCEDURE CODE/BILL TYPE IS INCONSISTENT WITH THE

PLACE OF SERVICE.

- 6 = THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S AGE.
- 7 = THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER.
- 8 = THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE.
- 9 = THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.
- 10 = THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER.
- 11 = THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE.
- 12 = THE DIAGNOSIS IS INCONSISTENT WITH THE PROVIDER TYPE.
- 13 = THE DATE OF DEATH PRECEDES THE DATE OF SERVICE.
- 14 = THE DATE OF BIRTH FOLLOWS THE DATE OF SERVICE.
- 15 = CLAIM/SERVICE ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
- 16 = CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR REVENUE CENTER ANSI CODE TABLE

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REV_CNTR_ANSI_TB

ADJUDICATION.

- 17 = CLAIM/SERVICE ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE.
- 18 = DUPLICATE CLAIM/SERVICE.
- 19 = CLAIM DENIED BECAUSE THIS IS A WORK-RELATED INJURY/ILLNESS AND THUS THE LIABILITY OF THE WORKER'S COMPENSATION CARRIER.
- 20 = CLAIM DENIED BECAUSE THIS INJURY/ILLNESS IS COVERED BY THE LIABILITY CARRIER.
- 21 = CLAIM DENIED BECAUSE THIS INJURY/ILLNESS IS THE LIABILITY OF THE NO-FAULT CARRIER.
- 22 = CLAIM ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
- 23 = CLAIM ADJUSTED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER.
- 24 = PAYMENT FOR CHARGES ADJUSTED. CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.
- 25 = PAYMENT DENIED. YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET.
- 26 = EXPENSES INCURRED PRIOR TO COVERAGE.
- 27 = EXPENSES INCURRED AFTER COVERAGE TERMINATED.
- 28 = COVERAGE NOT IN EFFECT AT THE TIME THE SERVICE WAS PROVIDED.

29 = THE TIME LIMIT FOR FILING HAS EXPIRED.
30 = CLAIM/SERVICE ADJUSTED BECAUSE THE PATIENT HAS NOT MET
THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR
RESIDENCY REQUIREMENTS.
31 = CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR
INSURED.
32 = OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN
ELIGIBLE DEPENDENT AS DEFINED.
33 = CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE.
34 = CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS.
35 = BENEFIT MAXIMUM HAS BEEN REACHED.
36 = BALANCE DOES NOT EXCEED COPAYMENT AMOUNT.
37 = BALANCE DOES NOT EXCEED DEDUCTIBLE AMOUNT.
38 = SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED
(NETWORK) PROVIDERS.
39 = SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTI-
FICATION WAS REQUESTED.
40 = CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENCY/URGENT
CARE.
41 = DISCOUNT AGREED TO IN PREFERRED PROVIDER CONTRACT.
42 = CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE
AMOUNT.
43 = GRAMM-RUDMAN REDUCTION.
44 = PROMPT-PAY DISCOUNT.
45 = CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGE-
MENT.
46 = THIS (THESE) SERVICE(S) IS(ARE) NOT COVERED.
47 = THIS (THESE) DIAGNOSIS(ES) IS(ARE) NOT COVERED,
MISSING, OR ARE INVALID.
48 = THIS (THESE) PROCEDURE(S) IS(ARE) NOT COVERED.
49 = THESE ARE NON-COVERED SERVICES BECAUSE THIS IS A
ROUTINE EXAM OR SCREENING PROCEDURE DONE IN CONJUNC-
TION WITH A ROUTINE EXAM.
50 = THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT
DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
REVENUE CENTER ANSI CODE TABLE

1 REV_CNTR_ANSI_TB

51 = THESE ARE NON-COVERED SERVICES BECAUSE THIS A PRE-
EXISTING CONDITION.
52 = THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT
ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE
BILLED.
53 = SERVICES BY AN IMMEDIATE RELATIVE OR A MEMBER OF THE

SAME HOUSEHOLD ARE NOT COVERED.

54 = MULTIPLE PHYSICIANS/ASSISTANTS ARE NOT COVERED IN THIS CASE.

55 = CLAIM/SERVICE DENIED BECAUSE PROCEDURE/TREATMENT IS DEEMED EXPERIMENTAL/INVESTIGATIONAL BY THE PAYER.

56 = CLAIM/SERVICE DENIED BECAUSE PROCEDURE/TREATMENT HAS NOT BEEN DEEMED 'PROVEN TO BE EFFECTIVE' BY PAYER.

57 = CLAIM/SERVICE ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, OR THIS DOSAGE.

58 = CLAIM/SERVICE ADJUSTED BECAUSE TREATMENT WAS DEEMED BY THE PAYER TO HAVE BEEN RENDERED IN AN INAPPROPRIATE OR INVALID PLACE OF SERVICE.

59 = CHARGES ARE ADJUSTED BASED ON MULTIPLE SURGERY RULES OR CONCURRENT ANESTHESIA RULES.

60 = CHARGES FOR OUTPATIENT SERVICES WITH THE PROXIMITY TO INPATIENT SERVICES ARE NOT COVERED.

61 = CHARGES ADJUSTED AS PENALTY FOR FAILURE TO OBTAIN SECOND SURGICAL OPINION.

62 = CLAIM/SERVICE DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRECERTIFICATION/AUTHORIZATION.

63 = CORRECTION TO A PRIOR CLAIM. INACTIVE

64 = DENIAL REVERSED PER MEDICAL REVIEW. INACTIVE

65 = PROCEDURE CODE WAS INCORRECT. THIS PAYMENT REFLECTS THE CORRECT CODE. INACTIVE

66 = BLOOD DEDUCTIBLE.

67 = LIFETIME RESERVE DAYS. INACTIVE

68 = DRG WEIGHT. INACTIVE

69 = DAY OUTLIER AMOUNT.

70 = COST OUTLIER AMOUNT.

71 = PRIMARY PAYER AMOUNT.

72 = COINSURANCE DAY. INACTIVE

73 = ADMINISTRATIVE DAYS. INACTIVE

74 = INDIRECT MEDICAL EDUCATION ADJUSTMENT.

75 = DIRECT MEDICAL EDUCATION ADJUSTMENT.

76 = DISPROPORTIONATE SHARE ADJUSTMENT.

77 = COVERED DAYS. INACTIVE

78 = NON-COVERED DAYS/ROOM CHARGE ADJUSTMENT.

79 = COST REPORT DAYS. INACTIVE

80 = OUTLIER DAYS. INACTIVE

81 = DISCHARGES. INACTIVE

82 = PIP DAYS. INACTIVE

83 = TOTAL VISITS. INACTIVE

1 REV_CNTR_ANSI_TB

84 = CAPITAL ADJUSTMENTS. INACTIVE
85 = INTEREST AMOUNT. INACTIVE
86 = STATUTORY ADJUSTMENT. INACTIVE
87 = TRANSFER AMOUNTS.
88 = ADJUSTMENT AMOUNT REPRESENTS COLLECTION AGAINST
 RECEIVABLE CREATED IN PRIOR OVERPAYMENT.
89 = PROFESSIONAL FEES REMOVED FROM CHARGES.
90 = INGREDIENT COST ADJUSTMENT.

REVENUE CENTER ANSI CODE TABLE

91 = DISPENSING FEE ADJUSTMENT.
92 = CLAIM PAID IN FULL. INACTIVE
93 = NO CLAIM LEVEL ADJUSTMENT. INACTIVE
94 = PROCESS IN EXCESS OF CHARGES.
95 = BENEFITS ADJUSTED. PLAN PROCEDURES NOT FOLLOWED.
96 = NON-COVERED CHARGES.
97 = PAYMENT IS INCLUDED IN ALLOWANCE FOR ANOTHER
 SERVICE/PROCEDURE.
98 = THE HOSPITAL MUST FILE THE MEDICARE CLAIM FOR THIS
 INPATIENT NON-PHYSICIAN SERVICE. INACTIVE
99 = MEDICARE SECONDARY PAYER ADJUSTMENT AMOUNT. INACTIVE
100 = PAYMENT MADE TO PATIENT/INSURED/RESPONSIBLE PARTY.
101 = PREDETERMINATION: ANTICIPATED PAYMENT UPON COMPLE-
 TION OF SERVICES OR CLAIM ADJUDICATION.
102 = MAJOR MEDICAL ADJUSTMENT.
103 = PROVIDER PROMOTIONAL DISCOUNT (I.E. SENIOR CITIZEN
 DISCOUNT).
104 = MANAGED CARE WITHHOLDING.
105 = TAX WITHHOLDING.
106 = PATIENT PAYMENT OPTION/ELECTION NOT IN EFFECT.
107 = CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING
 CLAIM/SERVICE WAS NOT PAID OR IDENTIFIED ON THE CLAIM.
108 = CLAIM/SERVICE REDUCED BECAUSE RENT/PURCHASE GUIDELINES
 WERE NOT MET.
109 = CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST
 SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR.
110 = BILLING DATE PREDATES SERVICE DATE.
111 = NOT COVERED UNLESS THE PROVIDER ACCEPTS ASSIGNMENT.
112 = CLAIM/SERVICE ADJUSTED AS NOT FURNISHED DIRECTLY
 TO THE PATIENT AND/OR NOT DOCUMENTED.
113 = CLAIM DENIED BECAUSE SERVICE/PROCEDURE WAS PROVIDED
 OUTSIDE THE UNITED STATES OR AS A RESULT OF WAR.
114 = PROCEDURE/PRODUCT NOT APPROVED BY THE FOOD AND DRUG

ADMINISTRATION.

115 = CLAIM/SERVICE ADJUSTED AS PROCEDURE POSTPONED OR
CANCELED.

116 = CLAIM/SERVICE DENIED. THE ADVANCE INDEMNIFICATION
NOTICE SIGNED BY THE PATIENT DID NOT COMPLY WITH
REQUIREMENTS.

117 = CLAIM/SERVICE ADJUSTED BECAUSE TRANSPORTATION IS ONLY
COVERED TO THE CLOSEST FACILITY THAT CAN PROVIDE
THE NECESSARY CARE.

118 = CHARGES REDUCED FOR ESRD NETWORK SUPPORT.

119 = BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.

120 = PATIENT IS COVERED BY A MANAGED CARE PLAN. INACTIVE

121 = INDEMNIFICATION ADJUSTMENT.

122 = PSYCHIATRIC REDUCTION.

123 = PAYER REFUND DUE TO OVERPAYMENT. INACTIVE

124 = PAYER REFUND AMOUNT - NOT OUR PATIENT. INACTIVE

125 = CLAIM/SERVICE ADJUSTED DUE TO A SUBMISSION/BILLING
ERROR(S).

126 = DEDUCTIBLE - MAJOR MEDICAL.

127 = COINSURANCE - MAJOR MEDICAL.

128 = NEWBORN'S SERVICES ARE COVERED IN THE MOTHER'S
ALLOWANCE.

129 = CLAIM DENIED - PRIOR PROCESSING INFORMATION APPEARS
INCORRECT.

130 = PAPER CLAIM SUBMISSION FEE.

REVENUE CENTER ANSI CODE TABLE

131 = CLAIM SPECIFIC NEGOTIATED DISCOUNT.

132 = PREARRANGED DEMONSTRATION PROJECT ADJUSTMENT.

133 = THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING
FURTHER REVIEW.

134 = TECHNICAL FEES REMOVED FROM CHARGES.

135 = CLAIM DENIED. INTERIM BILLS CANNOT BE PROCESSED.

136 = CLAIM ADJUSTED. PLAN PROCEDURES OF A PRIOR PAYER
WERE NOT FOLLOWED.

137 = PAYMENT/REDUCTION FOR REGULATORY SURCHARGES, ASSESS-
MENTS, ALLOWANCES OR HEALTH RELATED TAXES.

138 = CLAIM/SERVICE DENIED. APPEAL PROCEDURES NOT
FOLLOWED OR TIME LIMITS NOT MET.

139 = CONTRACTED FUNDING AGREEMENT - SUBSCRIBER IS EMPLOYED
BY THE PROVIDER OF SERVICES.

140 = PATIENT/INSURED HEALTH IDENTIFICATION NUMBER AND NAME
DO NOT MATCH.

1 REV_CNTR_ANSI_TB

141 = CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE
AND INELIGIBLE PERIODS OF COVERAGE.
142 = CLAIM ADJUSTED BY THE MONTHLY MEDICAID PATIENT
LIABILITY AMOUNT.
A0 = PATIENT REFUND AMOUNT
A1 = CLAIM DENIED CHARGES.
A2 = CONTRACTUAL ADJUSTMENT.
A3 = MEDICARE SECONDARY PAYER LIABILITY MET. INACTIVE
A4 = MEDICARE CLAIM PPS CAPITAL DAY OUTLIER AMOUNT.
A5 = MEDICARE CLAIM PPS CAPITAL COST OUTLIER AMOUNT.
A6 = PRIOR HOSPITALIZATION OR 30 DAY TRANSFER REQUIREMENT
NOT MET.
A7 = PRESUMPTIVE PAYMENT ADJUSTMENT.
A8 = CLAIM DENIED; UNGROUPABLE DRG.
B1 = NON-COVERED VISITS.
B2 = COVERED VISITS. INACTIVE
B3 = COVERED CHARGES. INACTIVE
B4 = LATE FILING PENALTY.
B5 = CLAIM/SERVICE ADJUSTED BECAUSE COVERAGE/PROGRAM
GUIDELINES WERE NOT MET OR WERE EXCEEDED.
B6 = THIS SERVICE/PROCEDURE IS ADJUSTED WHEN PERFORMED/
BILLED BY THIS TYPE OF PROVIDER, BY THIS TYPE OF
FACILITY, OR BY A PROVIDER OF THIS SPECIALTY.
B7 = THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE
PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF
SERVICE.
B8 = CLAIM/SERVICE NOT COVERED/REDUCED BECAUSE ALTER-
NATIVE SERVICES WERE AVAILABLE, AND SHOULD HAVE
BEEN UTILIZED.
B9 = SERVICES NOT COVERED BECAUSE THE PATIENT IS EN-
ROLLED IN A HOSPICE.
B10 = ALLOWED AMOUNT HAS BEEN REDUCED BECAUSE A COM-
PONENT OF THE BASIC PROCEDURE/TEST WAS PAID. THE
BENEFICIARY IS NOT LIABLE FOR MORE THAN THE CHARGE
LIMIT FOR THE BASIC PROCEDURE/TEST.
B11 = THE CLAIM/SERVICE HAS BEEN TRANSFERRED TO THE
PROPER PAYER/PROCESSOR FOR PROCESSING. CLAIM/
SERVICE NOT COVERED BY THIS PAYER/PROCESSOR.
B12 = SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RE-
CORDS.
B13 = PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE
MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.

REVENUE CENTER ANSI CODE TABLE

1 REV_CNTR_ANSI_TB

B14 = CLAIM/SERVICE DENIED BECAUSE ONLY ONE VISIT OR
CONSULTATION PER PHYSICIAN PER DAY IS COVERED.
B15 = CLAIM/SERVICE ADJUSTED BECAUSE THIS PROCEDURE/
SERVICE IS NOT PAID SEPARATELY.
B16 = CLAIM/SERVICE ADJUSTED BECAUSE 'NEW PATIENT'
QUALIFICATIONS WERE NOT MET.
B17 = CLAIM/SERVICE ADJUSTED BECAUSE THIS SERVICE WAS
NOT PRESCRIBED BY A PHYSICIAN, NOT PRESCRIBED
PRIOR TO DELIVERY, THE PRESCRIPTION IS INCOMPLETE,
OR THE PRESCRIPTION IS NOT CURRENT.
B18 = CLAIM/SERVICE DENIED BECAUSE THIS PROCEDURE CODE/
MODIFIER WAS INVALID ON THE DATE OF SERVICE OR
CLAIM SUBMISSION.
B19 = CLAIM/SERVICE ADJUSTED BECAUSE OF THE FINDING OF A
REVIEW ORGANIZATION. INACTIVE
B20 = CHARGES ADJUSTED BECAUSE PROCEDURE/SERVICE WAS
PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.
B21 = THE CHARGES WERE REDUCED BECAUSE THE SERVICE/CARE
WAS PARTIALLY FURNISHED BY ANOTHER PHYSICIAN.
INACTIVE
B22 = THIS CLAIM/SERVICE IS ADJUSTED BASED ON THE
DIAGNOSIS.
B23 = CLAIM/SERVICE DENIED BECAUSE THIS PROVIDER HAS
FAILED AN ASPECT OF A PROFICIENCY TESTING PROGRAM.
W1 = WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

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REV_CNTR_APC_TB
-----REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

0001 = PHOTOCHEMOTHERAPY
0002 = FINE NEEDLE BIOPSY/ASPIRATION
0003 = BONE MARROW BIOPSY/ASPIRATION
0004 = LEVEL I NEEDLE BIOPSY/ ASPIRATION EXCEPT
BONE MARROW
0005 = LEVEL II NEEDLE BIOPSY /ASPIRATION EXCEPT
BONE MARROW
0006 = LEVEL I INCISION & DRAINAGE
0007 = LEVEL II INCISION & DRAINAGE
0008 = LEVEL III INCISION & DRAINAGE
0009 = NAIL PROCEDURES
0010 = LEVEL I DESTRUCTION OF LESION
0011 = LEVEL II DESTRUCTION OF LESION

0012 = LEVEL I DEBRIDEMENT & DESTRUCTION
0013 = LEVEL II DEBRIDEMENT & DESTRUCTION
0014 = LEVEL III DEBRIDEMENT & DESTRUCTION
0015 = LEVEL IV DEBRIDEMENT & DESTRUCTION
0016 = LEVEL V DEBRIDEMENT & DESTRUCTION
0017 = LEVEL VI DEBRIDEMENT & DESTRUCTION
0018 = BIOPSY SKIN, SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE
0019 = LEVEL I EXCISION/ BIOPSY
0020 = LEVEL II EXCISION/ BIOPSY
0021 = LEVEL III EXCISION/ BIOPSY
0022 = LEVEL IV EXCISION/ BIOPSY
0023 = EXPLORATION PENETRATING WOUND
0024 = LEVEL I SKIN REPAIR
0025 = LEVEL II SKIN REPAIR
0026 = LEVEL III SKIN REPAIR
0027 = LEVEL IV SKIN REPAIR
0029 = INCISION/EXCISION BREAST
0030 = BREAST RECONSTRUCTION/MASTECTOMY
0031 = HYPERBARIC OXYGEN
0032 = PLACEMENT TRANSVENOUS CATHETERS/ARTERIAL CUTDOWN
0033 = PARTIAL HOSPITALIZATION
0040 = ARTHROCENTESIS & LIGAMENT/TENDON INJECTION
0041 = ARTHROSCOPY
0042 = ARTHROSCOPICALLY-AIDED PROCEDURES
0043 = CLOSED TREATMENT FRACTURE FINGER/TOE/TRUNK
0044 = CLOSED TREATMENT FRACTURE/DISLOCATION EXCEPT
FINGER/TOE/TRUNK
0045 = BONE/JOINT MANIPULATION UNDER ANESTHESIA
0046 = OPEN/PERCUTANEOUS TREATMENT FRACTURE OR DISLOCATION
0047 = ARTHROPLASTY WITHOUT PROSTHESIS
0048 = ARTHROPLASTY WITH PROSTHESIS
0049 = LEVEL I MUSCULOSKELETAL PROCEDURES EXCEPT HAND
AND FOOT
0050 = LEVEL II MUSCULOSKELETAL PROCEDURES EXCEPT HAND
AND FOOT
0051 = LEVEL III MUSCULOSKELETAL PROCEDURES EXCEPT HAND
AND FOOT
0052 = LEVEL IV MUSCULOSKELETAL PROCEDURES EXCEPT HAND
AND FOOT
0053 = LEVEL I HAND MUSCULOSKELETAL PROCEDURES
0054 = LEVEL II HAND MUSCULOSKELETAL PROCEDURES
0055 = LEVEL I FOOT MUSCULOSKELETAL PROCEDURES
0056 = LEVEL II FOOT MUSCULOSKELETAL PROCEDURES
0057 = BUNION PROCEDURES

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REV_CNTR_APC_TB
-----REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

0058 = LEVEL I STRAPPING AND CAST APPLICATION
0059 = LEVEL II STRAPPING AND CAST APPLICATION
0060 = MANIPULATION THERAPY
0070 = THORACENTESIS/LAVAGE PROCEDURES
0071 = LEVEL I ENDOSCOPY UPPER AIRWAY
0072 = LEVEL II ENDOSCOPY UPPER AIRWAY
0073 = LEVEL III ENDOSCOPY UPPER AIRWAY
0074 = LEVEL IV ENDOSCOPY UPPER AIRWAY
0075 = LEVEL V ENDOSCOPY UPPER AIRWAY
0076 = ENDOSCOPY LOWER AIRWAY
0077 = LEVEL I PULMONARY TREATMENT
0078 = LEVEL II PULMONARY TREATMENT
0079 = VENTILATION INITIATION AND MANAGEMENT
0080 = DIAGNOSTIC CARDIAC CATHETERIZATION
0081 = NON-CORONARY ANGIOPLASTY OR ATHERECTOMY
0082 = CORONARY ATHERECTOMY
0083 = CORONARY ANGIOSPLASTY
0084 = LEVEL I ELECTROPHYSIOLOGIC EVALUATION
0085 = LEVEL II ELECTROPHYSIOLOGIC EVALUATION
0086 = ABLATE HEART DYSRHYTHM FOCUS
0087 = CARDIAC ELECTROPHYSIOLOGIC RECORDING/MAPPING
0088 = THROMBECTOMY
0089 = LEVEL I IMPLANTATION/REMOVAL/REVISION OF PACEMAKER,
AICD VASCULAR DEVICE
0090 = LEVEL II IMPLANTATION/REMOVAL/REVISION OF PACEMAKER,
AICD VASCULAR DEVICE
0091 = LEVEL I VASCULAR LIGATION
0092 = LEVEL II VASCULAR LIGATION
0093 = VASCULAR REPAIR/FISTULA CONSTRUCTION
0094 = RESUSCITATION AND CARDIOVERSION
0095 = CARDIAC REHABILITATION
0096 = NON-INVASIVE VASCULAR STUDIES
0097 = CARDIOVASCULAR STRESS TEST
0098 = INJECTION OF SCLEROSING SOLUTION
0099 = CONTINUOUS CARDIAC MONITORING
0100 = CONTINUOUS ECG
0101 = TILT TABLE EVALUATION
0102 = ELECTRONIC ANALYSIS OF PACEMAKERS/OTHER DEVICES
0109 = BONE MARROW HARVESTING AND BONE MARROW/STEM CELL
TRANSPLANT
0110 = TRANSFUSION

1	<div style="display: flex; justify-content: space-between;"><div style="width: 25%;"><u>REV_CNTR_APC_TB</u> -----</div><div style="width: 75%;"><div style="margin-bottom: 10px;"><div>0111 = BLOOD PRODUCT EXCHANGE</div><div>0112 = EXTRACORPOREAL PHOTOPHERESIS</div><div>0113 = EXCISION LYMPHATIC SYSTEM</div><div>0114 = THYROID/LYMPHADENECTOMY PROCEDURES</div><div>0116 = CHEMOTHERAPY ADMINISTRATION BY OTHER TECHNIQUE EXCEPT INFUSION</div><div>0117 = CHEMOTHERAPY ADMINISTRATION BY INFUSION ONLY</div><div>0118 = CHEMOTHERAPY ADMINISTRATION BY BOTH INFUSION AND OTHER TECHNIQUE</div><div>0120 = INFUSION THERAPY EXCEPT CHEMOTHERAPY</div><div>0121 = LEVEL I TUBE CHANGES AND REPOSITIONING</div><div>0122 = LEVEL II TUBE CHANGES AND REPOSITIONING</div><div>0123 = LEVEL III TUBE CHANGES AND REPOSITIONING</div><div>0130 = LEVEL I LAPAROSCOPY</div><div>0131 = LEVEL II LAPAROSCOPY</div><div>0132 = LEVEL III LAPAROSCOPY</div><div>0140 = ESOPHAGEAL DILATION WITHOUT ENDOSCOPY</div></div><div><div>REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)</div><div>-----</div></div></div><div>0141 = UPPER GI PROCEDURES</div><div>0142 = SMALL INTESTINE ENDOSCOPY</div><div>0143 = LOWER GI ENDOSCOPY</div><div>0144 = DIAGNOSTIC ANOSCOPY</div><div>0145 = THERAPEUTIC ANOSCOPY</div><div>0146 = LEVEL I SIGMOIDOSCOPY</div><div>0147 = LEVEL II SIGMOIDOSCOPY</div><div>0148 = LEVEL I ANAL/RECTAL PROCEDURE</div><div>0149 = LEVEL II ANAL/RECTAL PROCEDURE</div><div>0150 = LEVEL III ANAL/RECTAL PROCEDURE</div><div>0151 = ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY (ERCP)</div><div>0152 = PERCUTANEOUS BILIARY ENDOSCOPIC PROCEDURES</div><div>0153 = PERITONEAL AND ABDOMINAL PROCEDURES</div><div>0154 = HERNIA/HYDROCELE PROCEDURES</div><div>0157 = COLORECTAL CANCER SCREENING: BARIUM ENEMA (NOT SUBJECT TO NATIONAL COINSURANCE)</div><div>0158 = COLORECTAL CANCER SCREENING: COLONOSCOPY NOT SUBJECT TO NATIONAL COINSURANCE. MINIMUM UNADJUSTED COINSURANCE IS 25% OF THE PAYMENT RATE. PAYMENT RATE IS LOWER OF THE HOPD PAYMENT RATE OR THE AMBULATORY SURGICAL CENTER PAYMENT.</div><div>0159 = COLORECTAL CANCER SCREENING: FLEXIBLE SIGMOIDOSCOPY NOT SUBJECT TO NATIONAL COINSURANCE. MINIMUM UNADJUSTED COINSURANCE IS 25% OF THE PAYMENT RATE.</div></div>
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PAYMENT RATE IS LOWER OF THE HOPD PAYMENT RATE OR
THE AMBULATORY SURGICAL CENTER PAYMENT.

0160 = LEVEL I CYSTOURETHROSCOPY AND OTHER GENITOURINARY
PROCEDURES

0161 = LEVEL II CYSTOURETHROSCOPY AND OTHER GENITOURINARY
PROCEDURES

0162 = LEVEL III CYSTOURETHROSCOPY AND OTHER GENITOURINARY
PROCEDURES

0163 = LEVEL IV CYSTOURETHROSCOPY AND OTHER GENITOURINARY
PROCEDURES

0164 = LEVEL I URINARY AND ANAL PROCEDURES

0165 = LEVEL II URINARY AND ANAL PROCEDURES

0166 = LEVEL I URETHRAL PROCEDURES

0167 = LEVEL II URETHRAL PROCEDURES

0168 = LEVEL III URETHRAL PROCEDURES

0169 = LITHOTRIPSY

0170 = DIALYSIS FOR OTHER THAN ESRD PATIENTS

0180 = CIRCUMCISION

0181 = PENILE PROCEDURES

0182 = INSERTION OF PENILE PROSTHESIS

0183 = TESTES/EPIDIDYMIS PROCEDURES

0184 = PROSTATE BIOPSY

0190 = SURGICAL HYSTEROSCOPY

0191 = LEVEL I FEMALE REPRODUCTIVE PROCEDURES

0192 = LEVEL II FEMALE REPRODUCTIVE PROCEDURES

0193 = LEVEL III FEMALE REPRODUCTIVE PROCEDURES

0194 = LEVEL IV FEMALE REPRODUCTIVE PROCEDURES

0195 = LEVEL V FEMALE REPRODUCTIVE PROCEDURES

0196 = DILATATION & CURETTAGE

0197 = INFERTILITY PROCEDURES

0198 = PREGNANCY AND NEONATAL CARE PROCEDURES

0199 = VAGINAL DELIVERY

0200 = THERAPEUTIC ABORTION

0201 = SPONTANEOUS ABORTION

REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

1 REV_CNTR_APC_TB

0210 = SPINAL TAP

0211 = LEVEL I NERVOUS SYSTEM INJECTIONS

0212 = LEVEL II NERVOUS SYSTEM INJECTIONS

0213 = EXTENDED EEG STUDIES AND SLEEP STUDIES

0214 = ELECTROENCEPHALOGRAM

0215 = LEVEL I NERVE AND MUSCLE TESTS

0216 = LEVEL II NERVE AND MUSCLE TESTS

0217 = LEVEL III NERVE AND MUSCLE TESTS
0220 = LEVEL I NERVE PROCEDURES
0221 = LEVEL II NERVE PROCEDURES
0222 = IMPLANTATION OF NEUROLOGICAL DEVICE
0223 = LEVEL I REVISION/REMOVAL NEUROLOGICAL DEVICE
0224 = LEVEL II REVISION/REMOVAL NEUROLOGICAL DEVICE
0225 = IMPLANTATION OF NEUROSTIMULATOR ELECTRODES
0230 = LEVEL I EYE TESTS
0231 = LEVEL II EYE TESTS
0232 = LEVEL I ANTERIOR SEGMENT EYE
0233 = LEVEL II ANTERIOR SEGMENT EYE
0234 = LEVEL III ANTERIOR SEGMENT EYE PROCEDURES
0235 = LEVEL I POSTERIOR SEGMENT EYE PROCEDURES
0236 = LEVEL II POSTERIOR SEGMENT EYE PROCEDURES
0237 = LEVEL III POSTERIOR SEGMENT EYE PROCEDURES
0238 = LEVEL I REPAIR AND PLASTIC EYE PROCEDURES
0239 = LEVEL II REPAIR AND PLASTIC EYE PROCEDURES
0240 = LEVEL III REPAIR AND PLASTIC EYE PROCEDURES
0241 = LEVEL IV REPAIR AND PLASTIC EYE PROCEDURES
0242 = LEVEL V REPAIR AND PLASTIC EYE PROCEDURES
0243 = STRABISMUS/MUSCLE PROCEDURES
0244 = CORNEAL TRANSPLANT
0245 = CATARACT PROCEDURES WITHOUT IOL INSERT
0246 = CATARACT PROCEDURES WITH IOL INSERT
0247 = LASER EYE PROCEDURES EXCEPT RETINAL
0248 = LASER RETINAL PROCEDURES
0250 = NASAL CAUTERIZATION/PACKING
0251 = LEVEL I ENT PROCEDURES
0252 = LEVEL II ENT PROCEDURES
0253 = LEVEL III ENT PROCEDURES
0254 = LEVEL IV ENT PROCEDURES
0256 = LEVEL V ENT PROCEDURES
0257 = IMPLANTATION OF COCHLEAR DEVICE
0258 = TONSIL AND ADENOID PROCEDURES
0260 = LEVEL I PLAIN FILM EXCEPT TEETH
0261 = LEVEL II PLAIN FILM EXCEPT TEETH INCLUDING BONE
DENSITY MEASUREMENT
0262 = PLAIN FILM OF TEETH
0263 = LEVEL I MISCELLANEOUS RADIOLOGY PROCEDURES
0264 = LEVEL II MISCELLANEOUS RADIOLOGY PROCEDURES
0265 = LEVEL I DIAGNOSTIC ULTRASOUND EXCEPT VASCULAR
0266 = LEVEL II DIAGNOSTIC ULTRASOUND EXCEPT VASCULAR
0267 = VASCULAR ULTRASOUND
0268 = GUIDANCE UNDER ULTRASOUND

1	REV_CNTR_APC_TB -----	0269 = ECHOCARDIOGRAM EXCEPT TRANSESOPHAGEAL 0270 = TRANSESOPHAGEAL ECHOCARDIOGRAM 0271 = MAMMOGRAPHY 0272 = LEVEL I FLUOROSCOPY 0273 = LEVEL II FLUOROSCOPY 0274 = MYELOGRAPHY 0275 = ARTHROGRAPHY REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC) ----- 0276 = LEVEL I DIGESTIVE RADIOLOGY 0277 = LEVEL II DIGESTIVE RADIOLOGY 0278 = DIAGNOSTIC UROGRAPHY 0279 = LEVEL I DIAGNOSTIC ANGIOGRAPHY AND VENOGRAPHY EXCEPT EXTREMITY 0280 = LEVEL II DIAGNOSTIC ANGIOGRAPHY AND VENOGRAPHY EXCEPT EXTREMITY 0281 = VENOGRAPHY OF EXTREMITY 0282 = LEVEL I COMPUTERIZED AXIAL TOMOGRAPHY 0283 = LEVEL II COMPUTERIZED AXIAL TOMOGRAPHY 0284 = MAGNETIC RESONANCE IMAGING 0285 = POSITRON EMISSION TOMOGRAPHY (PET) 0286 = MYOCARDIAL SCANS 0290 = STANDARD NON-IMAGING NUCLEAR MEDICINE 0291 = LEVEL I DIAGNOSTIC NUCLEAR MEDICINE EXCLUDING MYOCARDIAL SCANS 0292 = LEVEL II DIAGNOSTIC NUCLEAR MEDICINE EXCLUDING MYOCARDIAL SCANS 0294 = LEVEL I THERAPEUTIC NUCLEAR MEDICINE 0295 = LEVEL II THERAPEUTIC NUCLEAR MEDICINE 0296 = LEVEL I THERAPEUTIC RADIOLOGIC PROCEDURES 0297 = LEVEL II THERAPEUTIC RADIOLOGIC PROCEDURES 0300 = LEVEL I RADIATION THERAPY 0301 = LEVEL II RADIATION THERAPY 0302 = LEVEL III RADIATION THERAPY 0303 = TREATMENT DEVICE CONSTRUCTION 0304 = LEVEL I THERAPEUTIC RADIATION TREATMENT PREPARATION 0305 = LEVEL II THERAPEUTIC RADIATION TREATMENT PREPARATION 0310 = LEVEL III THERAPEUTIC RADIATION TREATMENT PREPARATION 0311 = RADIATION PHYSICS SERVICES 0312 = RADIOELEMENT APPLICATIONS
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1 REV_CNTR_APC_TB

0313 = BRACHYTHERAPY
0314 = HYPERTHERMIC THERAPIES
0320 = ELECTROCONVULSIVE THERAPY
0321 = BIOFEEDBACK AND OTHER TRAINING
0322 = BRIEF INDIVIDUAL PSYCHOTHERAPY
0323 = EXTENDED INDIVIDUAL PSYCHOTHERAPY
0324 = FAMILY PSYCHOTHERAPY
0325 = GROUP PSYCHOTHERAPY
0330 = DENTAL PROCEDURES
0340 = MINOR ANCILLARY PROCEDURES
0341 = IMMUNOLOGY TESTS
0342 = LEVEL I PATHOLOGY
0343 = LEVEL II PATHOLOGY
0344 = LEVEL III PATHOLOGY
0354 = ADMINISTRATION OF INFLUENZA VACCINE (NOT
SUBJECT TO NATIONAL COINSURANCE)
0355 = LEVEL I IMMUNIZATIONS
0356 = LEVEL II IMMUNIZATIONS
0357 = LEVEL III IMMUNIZATIONS
0358 = LEVEL IV IMMUNIZATIONS
0359 = INJECTIONS
0360 = LEVEL I ALIMENTARY TESTS
0361 = LEVEL II ALIMENTARY TESTS
0362 = FITTING OF VISION AIDS
REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

0363 = OTORHINOLARYNGOLOGIC FUNCTION TESTS
0364 = LEVEL I AUDIOMETRY
0365 = LEVEL II AUDIOMETRY
0366 = ELECTROCARDIOGRAM (ECG)
0367 = LEVEL I PULMONARY TEST
0368 = LEVEL II PULMONARY TEST
0369 = LEVEL III PULMONARY TEST
0370 = ALLERGY TESTS
0371 = ALLERGY INJECTIONS
0372 = THERAPEUTIC PHLEBOTOMY
0373 = NEUROPSYCHOLOGICAL TESTING
0374 = MONITORING PSYCHIATRIC DRUGS
0600 = LOW LEVEL CLINIC VISITS
0601 = MID LEVEL CLINIC VISITS
0602 = HIGH LEVEL CLINIC VISITS
0603 = INTERDISCIPLINARY TEAM CONFERENCE
0610 = LOW LEVEL EMERGENCY VISITS

0611 = MID LEVEL EMERGENCY VISITS
0612 = HIGH LEVEL EMERGENCY VISITS
0620 = CRITICAL CARE
0701 = STRONTIUM (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0702 = SAMARIAM (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0704 = SATUMOMAB PENDETIDE (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0705 = TC99 TETROFOSMIN (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0725 = LEUCOVORIN CALCIUM (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0726 = DEXRAZOXANE HYDROCHLORIDE (ELIGIBLE FOR PASS-)
THROUGH PAYMENTS)
0727 = INJECTION, ETIDRONATE DISODIUM (ELIGIBLE FOR
PASS-THROUGH PAYMENTS)
0728 = FILGRASTIM (G-CSF) (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0730 = PAMIDRONATE DISODIUM (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0731 = SARGRAMOSTIM (GM-CSF) (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0732 = MESNA (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0733 = EPOETIN ALPHA (ELIGIBLE FOR PASS-THROUGH)
PAYMENTS)
0750 = DOLASETRON MESYLATE 10 MG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0754 = METOCLOPRAMIDE HCL (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0755 = THIETHYLPERAZINE MALEATE (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0761 = ORAL SUBSTITUTE FOR IV ANTIEMTIC (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0762 = DRONABINOL (ELIBIBLE FOR PASS-THROUGH PAYMENTS)
0763 = DOLASETRON MESYLATE 100 MG ORAL (ELIGIBLE FOR
PASS-THROUGH PAYMENTS)
0764 = GRANISETRON HCL, 100 MCG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0765 = GRANISETRON HCL, 1MG ORAL (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0768 = ONDANSETRON HYDROCHLORIDE PER 1 MG INJECTION
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

1 REV_CNTR_APC_TB

0769 = ONDANSETRON HYDROCHLORIDE 8 MG ORAL
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)

0800 = LEUPROLIDE ACETATE PER 3.75 MG (ELIGIBLE FOR
PASS-THROUGH PAYMENTS)

0801 = CYCLOPHOSPHAMIDE (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0802 = ETOPOSIDE (ELIGIBLE FOR PASS-THROUGH PAYMENTS)

0803 = MELPHALAN (ELIGIBLE FOR PASS-THROUGH PAYMENTS)

0807 = ALDESLEUKIN SINGLE USE VIAL (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)

0809 = BCG (INTRAVESICAL) ONE VIAL (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)

0810 = GOSERELIN ACETATE IMPLANT, PER 3.6 MG (ELIGIBLE FOR
PASS-THROUGH PAYMENTS)

0811 = CARBOPLATIN 50 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0812 = CARMUSTINE 100 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0813 = CISPLATIN 10 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0814 = ASPARAGINASE, 10,000 UNITS (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)

0815 = CYCLOPHOSPHAMIDE 100 MG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)

0816 = CYCLOPHOSPHAMIDE, LYOPHILIZED 100 MG (ELIGIBLE
FOR PASS-THROUGH PAYMENTS)

0817 = CYTRABINE 100 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0818 = DACTINOMYCIN 0.5 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0819 = DACARBAZINE 100 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0820 = DAUNORUBICIN HCI 10 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0821 = DAUNORUBICIN CITRATE, LIPOSOMAL FORMULATION, 10 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)

0822 = DIETHYLSTIBESTROL DIPHOSPHATE 250 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)

0823 = DOCETAXEL 20 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0824 = ETOPOSIDE 10 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

0826 = METHOTREXATE ORAL 2.5 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)

1	REV_CNTR_APC_TB -----	0827 = FLOXURIDINE 500 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0828 = GEMCITABINE HCL 200 MG (ELIGIBLE FOR PASS- THROUGH PAYMENTS) 0830 = IRINOTECAN 20 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0831 = IFOSFAMIDE PER 1 GRAM (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0832 = IDARUBICIN HYDROCHLORIDE 5 MG (ELIGIBLE FOR PASS- THROUGH PAYMENTS) 0833 = INTERFERON ALFACON-1, RECOMBINANT, 1 MCG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0834 = INTERFERON, ALFA-2A, RECOMBINANT 3 MILLION UNITS (ELIGIBLE FOR PASS-THROUGH PAYMENTS) REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC) ----- 0836 = INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0838 = INTERFERON, GAMMA 1-B, 3 MILLION UNITS (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0839 = MECHLORETHAMINE HCI 10 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0840 = MELPHALAN HCI 50 MG (ELIGIBLE FOR PASS- THROUGH PAYMENTS) 0841 = METHOTREXATE SODIUM 5 MG (ELIGIBLE FOR PASS- THROUGH PAYMENTS) 0842 = FLUDARABINE PHOSPHATE 50 MG (ELIGIBLE FOR PASS- THROUGH PAYMENTS) 0843 = PEGASPARGASE PER SINGLE DOSE VIAL (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0844 = PENTOSTATIN 10 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0847 = DOXORUBICIN HCL 10 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0849 = RITUXIMAB, 100 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0850 = STREPTOZOCIN 1 GM (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0851 = THIOTEPA 15 MG (ELIGIBLE FOR PASS-THROUGH PAY- MENTS) 0852 = TOPOTECAN 4 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS) 0853 = VINBLASTINE SULFATE 1 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
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0854 = VINCRISTINE SULFATE 1 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0855 = VINORELBINE TARTRATE PER 10 MG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0856 = PORFIMER SODIUM 75 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0857 = BLEOMYCIN SULFATE 15 UNITS (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0858 = CLADRIBINE, 1MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0859 = FLUOROURACIL (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0860 = PLICAMYCIN 2.5 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0861 = LEUPROLIDE ACETATE 1 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0862 = MITOMYCIN, 5MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0863 = PACLITAXEL, 30MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0864 = MITOXANTRONE HCL, PER 5MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0865 = INTERFERON ALFA-N3, 250,000 IU (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0884 = RHO (D) IMMUNE GLOBULIN, HUMAN ONE DOSE PACK
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0886 = AZATHIOPRINE, 50 MG ORAL
(NOT SUBJECT TO NATIONAL COINSURANCE)
0887 = AZATHIOPRINE, PARENTERAL 100 MG, 20 ML EACH INJECTION
(NOT SUBJECT TO NATIONAL COINSURANCE)
0888 = CYCLOSPORINE, ORAL 100 MG
(NOT SUBJECT TO NATIONAL COINSURANCE)
0889 = CYCLOSPORINE, PARENTERAL
(NOT SUBJECT TO NATIONAL COINSURANCE)
0890 = LYMPHOCYTE IMMUNE GLOBULIN 50 MG/ ML, 5 ML EACH
(NOT SUBJECT TO NATIONAL COINSURANCE)
REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

1 REV_CNTR_APC_TB

0891 = TACROLIMUS PER 1 MG ORAL
(NOT SUBJECT TO NATIONAL COINSURANCE)
0892 = DACLIZUMAB, PARENTERAL, 25 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0900 = INJECTION, ALGLUCERASE PER 10 UNITS
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0901 = ALPHA I, PROTEINASE INHIBITOR, HUMAN PER 10MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0902 = BOTULINUM TOXIN, TYPE A PER UNIT
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)

0903 = CMV IMMUNE GLOBULIN
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0905 = IMMUNE GLOBULIN PER 500 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0906 = RSV IMMUNE GLOBULIN
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0907 = GANCICLOVIR SODIUM 500 MG INJECTION
(NOT SUBJECT TO NATIONAL COINSURANCE)
0908 = TETANUS IMMUNE GLOBULIN, HUMAN, UP TO 250 UNITS
(NOT SUBJECT TO NATIONAL COINSURANCE)
0909 = INTERFERON BETA - 1A 33 MCG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0910 = INTERFERON BETA - 1B 0.25 MG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0911 = STREPTOKINASE PER 250,000 IU
(NOT SUBJECT TO NATIONAL COINSURANCE)
0913 = GANCICLOVIR 4.5 MG, IMPLANT (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0914 = RETEPLASE, 37.6 MG (TWO SINGLE USE VIALS)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0915 = ALTEPLASE RECOMBINANT, 10MG
(NOT SUBJECT TO NATIONAL COINSURANCE)
0916 = IMIGLUCERASE PER UNIT (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0917 = DIPYRIDAMOLE, 10MG / ADENOSINE 6MG
(NOT SUBJECT TO NATIONAL COINSURANCE)
0918 = BRACHYTHERAPY SEEDS, ANY TYPE, EACH (ELIGIBLE
FOR PASS-THROUGH PAYMENTS)
0925 = FACTOR VIII (ANTIHEMOPHILIC FACTOR, HUMAN) PER IU
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0926 = FACTOR VIII (ANTIHEMOPHILIC FACTOR, PORCINE) PER IU
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0927 = FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT)
PER IU (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0928 = FACTOR IX, COMPLEX (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
0929 = OTHER HEMOPHILIA CLOTTING FACTORS PER IU (ELIGIBLE
FOR PASS-THROUGH PAYMENTS)
0930 = ANTITHROMBIN III (HUMAN) PER IU (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
0931 = FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-
RECOMBINANT) (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
0932 = FACTOR IX (ANTIHEMOPHILIC FACTOR, RECOMBINANT)
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)

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0949 = PLASMA, POOLED MULTIPLE DONOR, SOLVENT/DETERGENT
TREATED, FROZEN (NOT SUBJECT TO NATIONAL COINSURANCE)
0950 = BLOOD (WHOLE) FOR TRANSFUSION (NOT SUBJECT TO
NATIONAL COINSURANCE)
REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

0952 = CRYOPRECIPITATE (NOT SUBJECT TO NATIONAL COINSURANCE)
0953 = FIBRINOGEN UNIT (NOT SUBJECT TO NATIONAL COINSURANCE)
0954 = LEUKOCYTE POOR BLOOD (NOT SUBJECT TO NATIONAL
COINSURANCE)
0955 = PLASMA, FRESH FROZEN (NOT SUBJECT TO NATIONAL
COINSURANCE)
0956 = PLASMA PROTEIN FRACTION (NOT SUBJECT TO NATIONAL
COINSURANCE)
0957 = PLATELET CONCENTRATE (NOT SUBJECT TO NATIONAL
COINSURANCE)
0958 = PLATELET RICH PLASMA (NOT SUBJECT TO NATIONAL
COINSURANCE)
0959 = RED BLOOD CELLS (NOT SUBJECT TO NATIONAL COINSURANCE)
0960 = WASHED RED BLOOD CELLS (NOT SUBJECT TO NATIONAL
COINSURANCE)
0961 = INFUSION, ALBUMIN (HUMAN) 5%, 500 ML
(NOT SUBJECT TO NATIONAL COINSURANCE)
0962 = INFUSION, ALBUMIN (HUMAN) 25%, 50 ML
(NOT SUBJECT TO NATIONAL COINSURANCE)
0970 = NEW TECHNOLOGY - LEVEL I (\$0 - \$50)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0971 = NEW TECHNOLOGY - LEVEL II (\$50 - \$100)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0972 = NEW TECHNOLOGY - LEVEL III (\$100 - \$200)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0973 = NEW TECHNOLOGY - LEVEL IV (\$200 - \$300)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0974 = NEW TECHNOLOGY - LEVEL V (\$300 - \$500)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0975 = NEW TECHNOLOGY - LEVEL VI (\$500 - \$750)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0976 = NEW TECHNOLOGY - LEVEL VII (\$750 - \$1000)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0977 = NEW TECHNOLOGY - LEVEL VIII (\$1000 - \$1250)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0978 = NEW TECHNOLOGY - LEVEL IX (\$1250 - \$1500)
(NOT SUBJECT TO NATIONAL COINSURANCE)

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0979 = NEW TECHNOLOGY - LEVEL X (\$1500 - \$1750)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0980 = NEW TECHNOLOGY - LEVEL XI (\$1750 - \$2000)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0981 = NEW TECHNOLOGY - LEVEL XII (\$2000 - \$2500)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0982 = NEW TECHNOLOGY - LEVEL XIII (\$2500 - \$3500)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0983 = NEW TECHNOLOGY - LEVEL XIV (\$3500 - \$5000)
(NOT SUBJECT TO NATIONAL COINSURANCE)
0984 = NEW TECHNOLOGY - LEVEL XV (\$5000 - \$6000)
(NOT SUBJECT TO NATIONAL COINSURANCE)
7000 = AMIFOSTINE, 500 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
7001 = AMPHOTERICIN B LIPID COMPLEX, 50 MG, INJ
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7002 = CLONIDINE, HCL, 1 MG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
7003 = EPOPROSTENOL, 0.5 MG, INJ (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
7004 = IMMUNE GLOBULIN INTRAVENOUS HUMAN 5G, INJ
REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7005 = GONADORELIN HCI, 100 MCG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
7007 = MILRINONE LACETATE, PER 5 ML, INJ (NOT SUBJECT
TO NATIONAL COINSURANCE)
7010 = MORPHINE SULFATE CONCENTRATE (PRESERVATIVE FREE)
PER 10 MG (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7011 = OPRELEVEKIN, INJ, 5 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
7012 = PENTAMIDINE ISETHIONATE, 300 MG (ELIGIBLE FOR
PASS-THROUGH PAYMENTS)
7014 = FENTANYL CITRATE, INJ, UP TO 2 ML (ELIGIBLE FOR
PASS-THROUGH PAYMENTS)
7015 = BUSULFAN, ORAL 2 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
7019 = APROTININ, 10,000 KIU (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
7021 = BACLOFEN, INTRATHECAL, 50 MCG (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
7022 = ELLIOTTS B SOLUTION, PER ML (ELIGIBLE FOR PASS-

THROUGH PAYMENTS)
7023 = TREATMENT FOR BLADDER CALCULI, I.E. RENACIDIN
PER 500 ML (ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7024 = CORTICORELIN OVINE TRIFLUTATE, 0.1 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7025 = DIGOXIN IMMUNE FAB (OVINE), 10 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7026 = ETHANOLAMINE OLEATE, 1000 ML
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7027 = FOMEPIZOLE, 1.5 G
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7028 = FOSPHENYTOIN, 50 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7029 = GLATIRAMER ACETATE, 25 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7030 = HEMIN, 1 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7031 = OCTREOTIDE ACETATE, 500 MCG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7032 = SERMORELIN ACETATE, 0.5 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7033 = SOMATREM, 5 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7034 = SOMATROPIN, 1 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7035 = TENIPOSIDE, 50 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7036 = UROKINASE, INJ, IV, 250,000 I.U.
(NOT SUBJECT TO NATIONAL COINSURANCE)
7037 = UROFOLLITROPIN, 75 I.U.
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7038 = MUROMONAB-CD3, 5 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7039 = PEGADEMASE BOVINE INJ 25 I.U.
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7040 = PENTASTARCH 10% INJ, 100 ML
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)
7041 = TIROFIBAN HCL, 0.5 MG
REVENUE CENTER AMBULATORY PAYMENT CLASSIFICATION (APC)

(NOT SUBJECT TO NATIONAL COINSURANCE)
7042 = CAPECITABINE, ORAL 150 MG
(ELIGIBLE FOR PASS-THROUGH PAYMENTS)

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7043 = INFlixIMAB, 10 MG (ELIGIBLE FOR PASS-THROUGH
PAYMENTS)
7045 = TRIMETREXATE GLUCORONATE (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)
7046 = DOXORUBICIN HCL LIPOSOME (ELIGIBLE FOR PASS-
THROUGH PAYMENTS)

1 REV_CNTR_DDCTBL_COINSRNC_TB

REVENUE CENTER DEDUCTIBLE COINSURANCE CODE

0 = CHARGES ARE SUBJECT TO DEDUCTIBLE
AND COINSURANCE
1 = CHARGES ARE NOT SUBJECT TO DEDUCTIBLE
2 = CHARGES ARE NOT SUBJECT TO COINSURANCE
3 = CHARGES ARE NOT SUBJECT TO DEDUCTIBLE
OR COINSURANCE
4 = NO CHARGE OR UNITS ASSOCIATED WITH THIS
REVENUE CENTER CODE. (FOR MULTIPLE
HCPCS PER SINGLE REVENUE CENTER CODE)

FOR REVENUE CENTER CODE 0001, THE FOLLOWING
MSP OVERRIDE VALUES MAY BE PRESENT:

M = OVERRIDE CODE; EGHP SERVICES INVOLVED
(EFF 12/90 FOR NON-INSTITUTIONAL CLAIMS;
10/93 FOR INSTITUTIONAL CLAIMS)
N = OVERRIDE CODE; NON-EGHP SERVICES INVOLVED
(EFF 12/90 FOR NON-INSTITUTIONAL CLAIMS;
10/93 FOR INSTITUTIONAL CLAIMS)
X = OVERRIDE CODE: MSP COST AVOIDED
(EFF 12/90 FOR NON-INSTITUTIONAL CLAIMS;
10/93 FOR INSTITUTIONAL CLAIMS)

1 REV_CNTR_PMT_MTHD_IND_TB

REVENUE CENTER PAYMENT METHOD INDICATOR TABLE

*****SERVICE INDICATOR*****
***** 1ST POSITION *****
A = SERVICES NOT PAID UNDER OPPTS
C = INPATIENT PROCEDURE
E = NONCOVERED ITEMS OR SERVICES
F = CORNEAL ISSUE ACQUISTION

G = CURRENT DRUG OR BIOLOGICAL PASS-THROUGH
H = DEVICE PASS-THROUGH
J = NEW DRUG OR NEW BIOLOGICAL PASS-THROUGH
N = PACKAGED INCIDENTAL SERVICE
P = PARTIAL HOSPITALIZATION SERVICES
S = SIGNIFICANT PROCEDURE NOT SUBJECT TO
MULTIPLE PROCEDURE DISCOUNTING
T = SIGNIFICANT PROCEDURE SUBJECT TO MULTIPLE
PROCEDURE DISCOUNTING
V = MEDICAL VISIT TO CLINIC OR EMERGENCY
DEPARTMENT
X = ANCILLARY SERVICE

*****PAYMENT INDICATOR*****
***** 2ND POSITION *****
1 = PAID STANDARD HOSPITAL OPPTS AMOUNT
(SERVICE INDICATORS S,T,V,X)
2 = SERVICES NOT PAID UNDER OPPTS (SERVICE
INDICATOR A, OR NO HCPCS CODE AND NOT
CERTAIN REVENUE CENTER CODES)
3 = NOT PAID (SERVICE INDICATORS C & E)
4 = ACQUISITION COST PAID (SERVICE INDICA-
TOR F)
5 = ADDITIONAL PAYMENT FOR CURRENT DRUG OR
BIOLOGICAL (SERVICE INDICATOR G)
6 = ADDITIONAL PAYMENT FOR DEVICE (SERVICE
INDICATOR H)
7 = ADDITIONAL PAYMENT FOR NEW DRUG OR NEW
BIOLOGICAL (SERVICE INDICATOR J)
8 = PAID PARTIAL HOSPITALIZATION PER DIEM
(SERVICE INDICATOR P)
9 = NO ADDITIONAL PAYMENT, PAYMENT INCLUDED
IN LINE ITEMS WITH APCS (SERVICE
INDICATOR N, OR NO HCPCS CODE AND CERTAIN
REVENUE CENTER CODES, OR HCPCS CODES Q0082
(ACTIVITY THERAPY), G0129 (OCCUPATIONAL
THERAPY) OR G0172 (PARTIAL HOSPITALIZATION
TRAINING)

1 REV_CNTR_PRICNG_IND_TB

REVENUE CENTER PRICING INDICATOR TABLE

- A = A VALID HCPCS CODE NOT SUBJECT TO A FEE SCHEDULE PAYMENT. REIMBURSEMENT IS CALCULATED ON PROVIDER SUBMITTED CHARGES.
- B = A VALID HCPCS CODE SUBJECT TO THE FEE SCHEDULE PAYMENT. REIMBURSEMENT IS THE LESSER OF PROVIDER SUBMITTED CHARGES OR THE FEE SCHEDULE AMOUNT.
- D = A VALID RADIOLOGY HCPCS CODE SUBJECT TO THE RADIOLOGY PRICER AND THE RATE IS REFLECTED AS ZEROES ON THE HCPCS FILE AND COST REPORT. THE RADIOLOGY PRICER TREATS THIS HCPCS AS A NON-COVERED SERVICE. REIMBURSEMENT IS CALCULATED ON PROVIDER SUBMITTED CHARGES.
- E = A VALID ASC HCPCS CODE SUBJECT TO THE ASC PRICER. THE RATE IS REFLECTED AS ZEROES ON THE HCPCS FILE. THE ASC PRICER DETERMINES THE ASC PAYMENT RATE AND IS REPORTED ON THE COST REPORT.
- F = A VALID ESRD HCPCS CODE SUBJECT TO THE PARAMETER RATE. REIMBURSEMENT IS THE LESSER OF PROVIDER SUBMITTED CHARGES OR THE FEE SCHEDULE AMOUNT FOR NON-DIALYSIS HCPCS. REIMBURSEMENT IS CALCULATED ON THE PROVIDER FILE RATES FOR DIALYSIS HCPCS.
- G = A VALID HCPCS, CODE IS SUBJECT TO A FEE SCHEDULE, BUT THE RATE IS NO LONGER PRESENT ON THE HCPCS FILE. REIMBURSEMENT IS CALCULATED ON PROVIDER SUBMITTED CHARGES.
- H = A VALID DME HCPCS, CODE IS SUBJECT TO A FEE SCHEDULE. THE RATES ARE REFLECTED UNDER THE DME SEGMENT. REIMBURSEMENT IS CALCULATED EITHER ON A FEE SCHEDULE, PROVIDER SUBMITTED CHARGES OR THE LESSER OF PROVIDER SUBMITTED, OR THE FEE SCHEDULE DEPENDING ON THE CATEGORY.
- I = A VALID DME CATEGORY 5 HCPCS, HCPCS IS NOT FOUND ON THE DME HISTORY RECORD, BUT A MATCH WAS FOUND ON HIC, CATEGORY AND GENERIC CODE. CLAIM MUST BE REVIEWED BY MEDICAL REVIEW BEFORE PAYMENT CAN BE CALCULATED.
- J = A VALID DME HCPCS, NO DME HISTORY IS PRESENT, AND A PRESCRIPTION IS REQUIRED BEFORE DELIVERY. CLAIM MUST BE REVIEWED BY MEDICAL REVIEW.
- K = A VALID DME HCPCS, PRESCRIBED HAS BEEN REVIEWED, AND FEE SCHEDULE PAYMENT IS APPROVED AS PRESCRIPTION WAS PRESENT BEFORE DELIVERY.
- L = A VALID TENS HCPCS, RENTAL PERIOD IS SIX MONTHS OR GREATER AND MUST BE REVIEWED BY MEDICAL REVIEW.
- M = A VALID TENS HCPCS, MEDICAL REVIEW HAS APPROVED THE

RENTAL CHARGE IN EXCESS OF FIVE MONTHS.

R = A VALID RADIOLOGY HCPCS CODE AND IS SUBJECT TO THE RADIOLOGY PRICER. THE RATE IS REPORTED ON THE COST REPORT. REIMBURSEMENT IS CALCULATED ON PROVIDER SUBMITTED CHARGES.

S = VALID INFLUENZA/PPV HCPCS. A FEE AMOUNT IS NOT APPLICABLE. THE AMOUNT PAYABLE IS PRESENT IN THE COVERED CHARGE FIELD. THIS AMOUNT IS NOT SUBJECT TO THE COINSURANCE AND DEDUCTIBLE. THIS CHARGE IS SUBJECT TO THE PROVIDER'S REIMBURSEMENT RATE.

T = VALID HCPCS. A FEE AMOUNT IS PRESENT. THE AMOUNT PAYABLE SHOULD BE THE LOWER OF THE BILLED CHARGE OR REVENUE CENTER PRICING INDICATOR TABLE

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FEE AMOUNT. THE SYSTEM SHOULD COMPUTE THE FEE AMOUNT BY MULTIPLYING THE COVERED UNITS TIMES THE RATE. THE FEE AMOUNT IS NOT SUBJECT TO COINSURANCE AND DEDUCTIBLE OR PROVIDER'S REIMBURSEMENT RATE.

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REVENUE CENTER TABLE

0001 = TOTAL CHARGE

0022 = SNF CLAIM PAID UNDER PPS SUBMITTED AS TOB 21X, EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 7/1/98 (DATES OF SERVICE AFTER 6/30/98). NOTE: THIS CODE MAY APPEAR MULTIPLE TIMES ON A CLAIM TO IDENTIFY DIFFERENT HIPPS RATE CODE/ASSESSMENT PERIODS.

0023 = HOME HEALTH SERVICES PAID UNDER PPS SUBMITTED AS TOB 32X AND 33X, EFFECTIVE 10/00. THIS CODE MAY APPEAR MULTIPLE TIMES ON A CLAIM TO IDENTIFY DIFFERENT HIPPS/HOME HEALTH RESOURCE GROUPS (HRG).

0100 = ALL INCLUSIVE RATE-ROOM AND BOARD PLUS ANCILLARY

0101 = ALL INCLUSIVE RATE-ROOM AND BOARD

0110 = PRIVATE MEDICAL OR GENERAL-GENERAL CLASSIFICATION

0111 = PRIVATE MEDICAL OR GENERAL-MEDICAL/SURGICAL/GYN

0112 = PRIVATE MEDICAL OR GENERAL-OB

0113 = PRIVATE MEDICAL OR GENERAL-PEDIATRIC

0114 = PRIVATE MEDICAL OR GENERAL-PSYCHIATRIC

0115 = PRIVATE MEDICAL OR GENERAL-HOSPICE

0116 = PRIVATE MEDICAL OR GENERAL-DETOXIFICATION

0117 = PRIVATE MEDICAL OR GENERAL-ONCOLOGY
0118 = PRIVATE MEDICAL OR GENERAL-REHABILITATION
0119 = PRIVATE MEDICAL OR GENERAL-OTHER
0120 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
GENERAL CLASSIFICATION
0121 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
MEDICAL/SURGICAL/GYN
0122 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-OB
0123 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-PEDIATRIC
0124 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-PSYCHIATRIC
0125 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-HOSPICE
0126 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
DETOXIFICATION
0127 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-ONCOLOGY
0128 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)
REHABILITATION
0129 = SEMI-PRIVATE 2 BED (MEDICAL OR GENERAL)-OTHER
0130 = SEMI-PRIVATE 3 AND 4 BEDS-GENERAL CLASSIFICATION
0131 = SEMI-PRIVATE 3 AND 4 BEDS-MEDICAL/SURGICAL/GYN
0132 = SEMI-PRIVATE 3 AND 4 BEDS-OB
0133 = SEMI-PRIVATE 3 AND 4 BEDS-PEDIATRIC
0134 = SEMI-PRIVATE 3 AND 4 BEDS-PSYCHIATRIC
0135 = SEMI-PRIVATE 3 AND 4 BEDS-HOSPICE
0136 = SEMI-PRIVATE 3 AND 4 BEDS-DETOXIFICATION
0137 = SEMI-PRIVATE 3 AND 4 BEDS-ONCOLOGY
0138 = SEMI-PRIVATE 3 AND 4 BEDS-REHABILITATION
0139 = SEMI-PRIVATE 3 AND 4 BEDS-OTHER
0140 = PRIVATE (DELUXE)-GENERAL CLASSIFICATION
0141 = PRIVATE (DELUXE)-MEDICAL/SURGICAL/GYN
0142 = PRIVATE (DELUXE)-OB
0143 = PRIVATE (DELUXE)-PEDIATRIC
0144 = PRIVATE (DELUXE)-PSYCHIATRIC
0145 = PRIVATE (DELUXE)-HOSPICE
0146 = PRIVATE (DELUXE)-DETOXIFICATION
0147 = PRIVATE (DELUXE)-ONCOLOGY
0148 = PRIVATE (DELUXE)-REHABILITATION
0149 = PRIVATE (DELUXE)-OTHER

REVENUE CENTER TABLE

0150 = ROOM&BOARD WARD (MEDICAL OR GENERAL)
GENERAL CLASSIFICATION
0151 = ROOM&BOARD WARD (MEDICAL OR GENERAL)
MEDICAL/SURGICAL/GYN

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0152 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-OB
0153 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-PEDIATRIC
0154 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-PSYCHIATRIC
0155 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-HOSPICE
0156 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-DETOXIFICATION
0157 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-ONCOLOGY
0158 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-REHABILITATION
0159 = ROOM&BOARD WARD (MEDICAL OR GENERAL)-OTHER
0160 = OTHER ROOM&BOARD-GENERAL CLASSIFICATION
0164 = OTHER ROOM&BOARD-STERILE ENVIRONMENT
0167 = OTHER ROOM&BOARD-SELF CARE
0169 = OTHER ROOM&BOARD-OTHER
0170 = NURSERY-GENERAL CLASSIFICATION
0171 = NURSERY-NEWBORN
 LEVEL I (ROUTINE)
0172 = NURSERY-PREMATURE
 NEWBORN-LEVEL II (CONTINUING CARE)
0173 = NURSERY-NEWBORN-LEVEL III (INTERMEDIATE CARE)
 (EFF 10/96)
0174 = NURSERY-NEWBORN-LEVEL IV (INTENSIVE CARE)
 (EFF 10/96)
0175 = NURSERY-NEONATAL ICU (OBSOLETE EFF 10/96)
0179 = NURSERY-OTHER
0180 = LEAVE OF ABSENCE-GENERAL CLASSIFICATION
0182 = LEAVE OF ABSENCE-PATIENT CONVENIENCE CHARGES
 BILLABLE
0183 = LEAVE OF ABSENCE-THERAPEUTIC LEAVE
0184 = LEAVE OF ABSENCE-ICF MENTALLY RETARDED-ANY REASON
0185 = LEAVE OF ABSENCE-NURSING HOME (HOSPITALIZATION)
0189 = LEAVE OF ABSENCE-OTHER LEAVE OF ABSENCE
0190 = SUBACUTE CARE - GENERAL CLASSIFICATION
 (EFF. 10/97)
0191 = SUBACUTE CARE - LEVEL I (EFF. 10/97)
0192 = SUBACUTE CARE - LEVEL II (EFF. 10/97)
0193 = SUBACUTE CARE - LEVEL III (EFF. 10/97)
0194 = SUBACUTE CARE - LEVEL IV (EFF. 10/97)
0199 = SUBACUTE CARE - OTHER (EFF 10/97)
0200 = INTENSIVE CARE-GENERAL CLASSIFICATION
0201 = INTENSIVE CARE-SURGICAL
0202 = INTENSIVE CARE-MEDICAL
0203 = INTENSIVE CARE-PEDIATRIC
0204 = INTENSIVE CARE-PSYCHIATRIC
0206 = INTENSIVE CARE-POST ICU; REDEFINED AS
 INTERMEDIATE ICU (EFF 10/96)

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0207 = INTENSIVE CARE-BURN CARE
0208 = INTENSIVE CARE-TRAUMA
0209 = INTENSIVE CARE-OTHER INTENSIVE CARE
0210 = CORONARY CARE-GENERAL CLASSIFICATION
0211 = CORONARY CARE-MYOCARDIAL INFRACTION
0212 = CORONARY CARE-PULMONARY CARE
0213 = CORONARY CARE-HEART TRANSPLANT
0214 = CORONARY CARE-POST CCU; REDEFINED AS
INTERMEDIATE CCU (EFF 10/96)
0219 = CORONARY CARE-OTHER CORONARY CARE
REVENUE CENTER TABLE

0220 = SPECIAL CHARGES-GENERAL CLASSIFICATION
0221 = SPECIAL CHARGES-ADMISSION CHARGE
0222 = SPECIAL CHARGES-TECHNICAL SUPPORT CHARGE
0223 = SPECIAL CHARGES-UR SERVICE CHARGE
0224 = SPECIAL CHARGES-LATE DISCHARGE, MEDICALLY
NECESSARY
0229 = SPECIAL CHARGES-OTHER SPECIAL CHARGES
0230 = INCREMENTAL NURSING CHARGE RATE-GENERAL
CLASSIFICATION
0231 = INCREMENTAL NURSING CHARGE RATE-NURSERY
0232 = INCREMENTAL NURSING CHARGE RATE-OB
0233 = INCREMENTAL NURSING CHARGE RATE-ICU (INCLUDE
TRANSITIONAL CARE)
0234 = INCREMENTAL NURSING CHARGE RATE-CCU (INCLUDE
TRANSITIONAL CARE)
0235 = INCREMENTAL NURSING CHARGE RATE-HOSPICE
0239 = INCREMENTAL NURSING CHARGE RATE-OTHER
0240 = ALL INCLUSIVE ANCILLARY-GENERAL CLASSIFICATION
0241 = ALL INCLUSIVE ANCILLARY-BASIC
0242 = ALL INCLUSIVE ANCILLARY-COMPREHENSIVE
0243 = ALL INCLUSIVE ANCILLARY-SPECIALTY
0249 = ALL INCLUSIVE ANCILLARY-OTHER INCLUSIVE ANCILLARY
0250 = PHARMACY-GENERAL CLASSIFICATION
0251 = PHARMACY-GENERIC DRUGS
0252 = PHARMACY-NONGENERIC DRUGS
0253 = PHARMACY-TAKE HOME DRUGS
0254 = PHARMACY-DRUGS INCIDENT TO OTHER DIAGNOSTIC SERVICE-
SUBJECT TO PAYMENT LIMIT
0255 = PHARMACY-DRUGS INCIDENT TO RADIOLOGY-
SUBJECT TO PAYMENT LIMIT
0256 = PHARMACY-EXPERIMENTAL DRUGS

0257 = PHARMACY-NON-PRESCRIPTION
0258 = PHARMACY-IV SOLUTIONS
0259 = PHARMACY-OTHER PHARMACY
0260 = IV THERAPY-GENERAL CLASSIFICATION
0261 = IV THERAPY-INFUSION PUMP
0262 = IV THERAPY-PHARMACY SERVICES (EFF 10/94)
0263 = IV THERAPY-DRUG SUPPLY/DELIVERY (EFF 10/94)
0264 = IV THERAPY-SUPPLIES (EFF 10/94)
0269 = IV THERAPY-OTHER IV THERAPY
0270 = MEDICAL/SURGICAL SUPPLIES-GENERAL CLASSIFICATION
(ALSO SEE 062X)
0271 = MEDICAL/SURGICAL SUPPLIES-NONSTERILE SUPPLY
0272 = MEDICAL/SURGICAL SUPPLIES-STERILE SUPPLY
0273 = MEDICAL/SURGICAL SUPPLIES-TAKE HOME SUPPLIES
0274 = MEDICAL/SURGICAL SUPPLIES-PROSTHETIC/ORTHOTIC
DEVICES
0275 = MEDICAL/SURGICAL SUPPLIES-PACE MAKER
0276 = MEDICAL/SURGICAL SUPPLIES-INTRAOCULAR LENS
0277 = MEDICAL/SURGICAL SUPPLIES-OXYGEN-TAKE HOME
0278 = MEDICAL/SURGICAL SUPPLIES-OTHER IMPLANTS
0279 = MEDICAL/SURGICAL SUPPLIES-OTHER DEVICES
0280 = ONCOLOGY-GENERAL CLASSIFICATION
0289 = ONCOLOGY-OTHER ONCOLOGY
0290 = DME (OTHER THAN RENAL)-GENERAL CLASSIFICATION
0291 = DME (OTHER THAN RENAL)-RENTAL
0292 = DME (OTHER THAN RENAL)-PURCHASE OF NEW DME
0293 = DME (OTHER THAN RENAL)-PURCHASE OF USED DME

REVENUE CENTER TABLE

0294 = DME (OTHER THAN RENAL)-RELATED TO AND LISTED AS DME
0299 = DME (OTHER THAN RENAL)-OTHER
0300 = LABORATORY-GENERAL CLASSIFICATION
0301 = LABORATORY-CHEMISTRY
0302 = LABORATORY-IMMUNOLOGY
0303 = LABORATORY-RENAL PATIENT (HOME)
0304 = LABORATORY-NON-ROUTINE DIALYSIS
0305 = LABORATORY-HEMATOLOGY
0306 = LABORATORY-BACTERIOLOGY & MICROBIOLOGY
0307 = LABORATORY-UROLOGY
0309 = LABORATORY-OTHER LABORATORY
0310 = LABORATORY PATHOLOGICAL-GENERAL CLASSIFICATION
0311 = LABORATORY PATHOLOGICAL-CYTOLOGY
0312 = LABORATORY PATHOLOGICAL-HISTOLOGY

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0314 = LABORATORY PATHOLOGICAL-BIOPSY
0319 = LABORATORY PATHOLOGICAL-OTHER
0320 = RADIOLOGY DIAGNOSTIC-GENERAL CLASSIFICATION
0321 = RADIOLOGY DIAGNOSTIC-ANGIOCARDIOGRAPHY
0322 = RADIOLOGY DIAGNOSTIC-ARTHROGRAPHY
0323 = RADIOLOGY DIAGNOSTIC-ARTERIOGRAPHY
0324 = RADIOLOGY DIAGNOSTIC-CHEST X-RAY
0329 = RADIOLOGY DIAGNOSTIC-OTHER
0330 = RADIOLOGY THERAPEUTIC-GENERAL CLASSIFICATION
0331 = RADIOLOGY THERAPEUTIC-CHEMOTHERAPY INJECTED
0332 = RADIOLOGY THERAPEUTIC-CHEMOTHERAPY ORAL
0333 = RADIOLOGY THERAPEUTIC-RADIATION THERAPY
0335 = RADIOLOGY THERAPEUTIC-CHEMOTHERAPY IV
0339 = RADIOLOGY THERAPEUTIC-OTHER
0340 = NUCLEAR MEDICINE-GENERAL CLASSIFICATION
0341 = NUCLEAR MEDICINE-DIAGNOSTIC
0342 = NUCLEAR MEDICINE-THERAPEUTIC
0349 = NUCLEAR MEDICINE-OTHER
0350 = COMPUTED TOMOGRAPHIC (CT) SCAN-GENERAL
CLASSIFICATION
0351 = CT SCAN-HEAD SCAN
0352 = CT SCAN-BODY SCAN
0359 = CT SCAN-OTHER CT SCANS
0360 = OPERATING ROOM SERVICES-GENERAL CLASSIFICATION
0361 = OPERATING ROOM SERVICES-MINOR SURGERY
0362 = OPERATING ROOM SERVICES-ORGAN TRANSPLANT,
OTHER THAN KIDNEY
0367 = OPERATING ROOM SERVICES-KIDNEY TRANSPLANT
0369 = OPERATING ROOM SERVICES-OTHER OPERATING ROOM
SERVICES
0370 = ANESTHESIA-GENERAL CLASSIFICATION
0371 = ANESTHESIA-INCIDENT TO RAD AND
SUBJECT TO THE PAYMENT LIMIT
0372 = ANESTHESIA-INCIDENT TO OTHER DIAGNOSTIC SERVICE
AND SUBJECT TO THE PAYMENT LIMIT
0374 = ANESTHESIA-ACUPUNCTURE
0379 = ANESTHESIA-OTHER ANESTHESIA
0380 = BLOOD-GENERAL CLASSIFICATION
0381 = BLOOD-PACKED RED CELLS
0382 = BLOOD-WHOLE BLOOD
0383 = BLOOD-PLASMA
0384 = BLOOD-PLATELETS
0385 = BLOOD-LEUKOCYTES
0386 = BLOOD-OTHER COMPONENTS

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REVENUE CENTER TABLE

0387 = BLOOD-OTHER DERIVATIVES (CRYOPRICIPATATES)
0389 = BLOOD-OTHER BLOOD
0390 = BLOOD STORAGE AND PROCESSING-GENERAL
CLASSIFICATION
0391 = BLOOD STORAGE AND PROCESSING-BLOOD
ADMINISTRATION
0399 = BLOOD STORAGE AND PROCESSING-OTHER
0400 = OTHER IMAGING SERVICES-GENERAL CLASSIFICATION
0401 = OTHER IMAGING SERVICES-DIAGNOSTIC MAMMOGRAPHY
0402 = OTHER IMAGING SERVICES-ULTRASOUND
0403 = OTHER IMAGING SERVICES-SCREENING MAMMOGRAPHY
(EFF 1/1/91)
0404 = OTHER IMAGING SERVICES-POSITRON EMISSION
TOMOGRAPHY (EFF 10/94)
0409 = OTHER IMAGING SERVICES-OTHER
0410 = RESPIRATORY SERVICES-GENERAL CLASSIFICATION
0412 = RESPIRATORY SERVICES-INHALATION SERVICES
0413 = RESPIRATORY SERVICES-HYPERBARIC OXYGEN THERAPY
0419 = RESPIRATORY SERVICES-OTHER
0420 = PHYSICAL THERAPY-GENERAL CLASSIFICATION
0421 = PHYSICAL THERAPY-VISIT CHARGE
0422 = PHYSICAL THERAPY-HOURLY CHARGE
0423 = PHYSICAL THERAPY-GROUP RATE
0424 = PHYSICAL THERAPY-EVALUATION OR RE-EVALUATION
0429 = PHYSICAL THERAPY-OTHER
0430 = OCCUPATIONAL THERAPY-GENERAL CLASSIFICATION
0431 = OCCUPATIONAL THERAPY-VISIT CHARGE
0432 = OCCUPATIONAL THERAPY-HOURLY CHARGE
0433 = OCCUPATIONAL THERAPY-GROUP RATE
0434 = OCCUPATIONAL THERAPY-EVALUATION OR RE-EVALUATION
0439 = OCCUPATIONAL THERAPY-OTHER (MAY INCLUDE
RESTORATIVE THERAPY)
0440 = SPEECH LANGUAGE PATHOLOGY-GENERAL CLASSIFICATION
0441 = SPEECH LANGUAGE PATHOLOGY-VISIT CHARGE
0442 = SPEECH LANGUAGE PATHOLOGY-HOURLY CHARGE
0443 = SPEECH LANGUAGE PATHOLOGY-GROUP RATE
0444 = SPEECH LANGUAGE PATHOLOGY-EVALUATION OR
RE-EVALUATION
0449 = SPEECH LANGUAGE PATHOLOGY-OTHER
0450 = EMERGENCY ROOM-GENERAL CLASSIFICATION
0451 = EMERGENCY ROOM-EMTALA EMERGENCY MEDICAL SCREENING

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SERVICES (EFF 10/96)
0452 = EMERGENCY ROOM-ER BEYOND EMTALA SCREENING
(EFF 10/96)
0456 = EMERGENCY ROOM-URGENT CARE (EFF 10/96)
0459 = EMERGENCY ROOM-OTHER
0460 = PULMONARY FUNCTION-GENERAL CLASSIFICATION
0469 = PULMONARY FUNCTION-OTHER
0470 = AUDIOLOGY-GENERAL CLASSIFICATION
0471 = AUDIOLOGY-DIAGNOSTIC
0472 = AUDIOLOGY-TREATMENT
0479 = AUDIOLOGY-OTHER
0480 = CARDIOLOGY-GENERAL CLASSIFICATION
0481 = CARDIOLOGY-CARDIAC CATH LAB
0482 = CARDIOLOGY-STRESS TEST
0483 = CARDIOLOGY-ECHOCARDIOLOGY
0489 = CARDIOLOGY-OTHER
0490 = AMBULATORY SURGICAL CARE-GENERAL CLASSIFICATION

REVENUE CENTER TABLE

0499 = AMBULATORY SURGICAL CARE-OTHER
0500 = OUTPATIENT SERVICES-GENERAL CLASSIFICATION
(DELETED 9/93)
0509 = OUTPATIENT SERVICES-OTHER (DELETED 9/93)
0510 = CLINIC-GENERAL CLASSIFICATION
0511 = CLINIC-CHRONIC PAIN CENTER
0512 = CLINIC-DENTAL CENTER
0513 = CLINIC-PSYCHIATRIC
0514 = CLINIC-OB-GYN
0515 = CLINIC-PEDIATRIC
0516 = CLINIC-URGENT CARE CLINIC (EFF 10/96)
0517 = CLINIC-FAMILY PRACTICE CLINIC (EFF 10/96)
0519 = CLINIC-OTHER
0520 = FREE-STANDING CLINIC-GENERAL CLASSIFICATION
0521 = FREE-STANDING CLINIC-RURAL HEALTH CLINIC
0522 = FREE-STANDING CLINIC-RURAL HEALTH HOME
0523 = FREE-STANDING CLINIC-FAMILY PRACTICE
0526 = FREE-STANDING CLINIC-URGENT CARE (EFF 10/96)
0529 = FREE-STANDING CLINIC-OTHER
0530 = OSTEOPATHIC SERVICES-GENERAL CLASSIFICATION
0531 = OSTEOPATHIC SERVICES-OSTEOPATHIC THERAPY
0539 = OSTEOPATHIC SERVICES-OTHER
0540 = AMBULANCE-GENERAL CLASSIFICATION
0541 = AMBULANCE-SUPPLIES

0542 = AMBULANCE-MEDICAL TRANSPORT
0543 = AMBULANCE-HEART MOBILE
0544 = AMBULANCE-OXYGEN
0545 = AMBULANCE-AIR AMBULANCE
0546 = AMBULANCE-NEO-NATAL AMBULANCE
0547 = AMBULANCE-PHARMACY
0548 = AMBULANCE-TELEPHONE TRANSMISSION EKG
0549 = AMBULANCE-OTHER
0550 = SKILLED NURSING-GENERAL CLASSIFICATION
0551 = SKILLED NURSING-VISIT CHARGE
0552 = SKILLED NURSING-HOURLY CHARGE
0559 = SKILLED NURSING-OTHER
0560 = MEDICAL SOCIAL SERVICES-GENERAL CLASSIFICATION
0561 = MEDICAL SOCIAL SERVICES-VISIT CHARGE
0562 = MEDICAL SOCIAL SERVICES-HOURLY CHARGES
0569 = MEDICAL SOCIAL SERVICES-OTHER
0570 = HOME HEALTH AID (HOME HEALTH)-GENERAL
CLASSIFICATION
0571 = HOME HEALTH AID (HOME HEALTH)-VISIT CHARGE
0572 = HOME HEALTH AID (HOME HEALTH)-HOURLY CHARGE
0579 = HOME HEALTH AID (HOME HEALTH)-OTHER
0580 = OTHER VISITS (HOME HEALTH)-GENERAL
CLASSIFICATION (UNDER HHPPS, NOT ALLOWED
AS COVERED CHARGES)
0581 = OTHER VISITS (HOME HEALTH)-VISIT CHARGE
(UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
0582 = OTHER VISITS (HOME HEALTH)-HOURLY CHARGE
(UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
0589 = OTHER VISITS (HOME HEALTH)-OTHER
(UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
0590 = UNITS OF SERVICE (HOME HEALTH)-GENERAL
CLASSIFICATION (UNDER HHPPS, NOT ALLOWED
AS COVERED CHARGES)
0599 = UNITS OF SERVICE (HOME HEALTH)-OTHER
REVENUE CENTER TABLE

(UNDER HHPPS, NOT ALLOWED AS COVERED CHARGES)
0600 = OXYGEN-GENERAL CLASSIFICATION
0601 = OXYGEN-STAT OR PORT EQUIP/SUPPLY OR COUNT
0602 = OXYGEN-STAT/EQUIP/UNDER 1 LPM
0603 = OXYGEN-STAT/EQUIP/OVER 4 LPM
0604 = OXYGEN-STAT/EQUIP/PORTABLE ADD-ON
0610 = MAGNETIC RESONANCE TECHNOLOGY (MRT)-GENERAL

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CLASSIFICATION

0611 = MRT/MRI-BRAIN (INCLUDING BRAINSTEM)

0612 = MRT/MRI-SPINAL CORD (INCLUDING SPINE)

0614 = MRT/MRI-OTHER

0615 = MRT/MRA-HEAD AND NECK

0616 = MRT/MRA-LOWER EXTREMITIES

0618 = MRT/MRA-OTHER

0619 = MRT/OTHER MRI

0621 = MEDICAL/SURGICAL SUPPLIES-INCIDENT TO RADIOLOGY-
SUBJECT TO THE PAYMENT LIMIT - EXTENSION OF 027X

0622 = MEDICAL/SURGICAL SUPPLIES-INCIDENT TO OTHER
DIAGNOSTIC SERVICE-SUBJECT TO THE PAYMENT LIMIT -
EXTENSION OF 027X

0623 = MEDICAL/SURGICAL SUPPLIES-SURGICAL DRESSINGS
(EFF 1/95) - EXTENSION OF 027X

0624 = MEDICAL/SURGICAL SUPPLIES-MEDICAL INVESTIGATIONAL
DEVICES AND PROCEDURES WITH FDA APPROVED IDE'S
(EFF 10/96) - EXTENSION OF 027X

0630 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-GENERAL
CLASSIFICATION

0631 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-SINGLE DRUG
SOURCE (EFF 9/93)

0632 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-MULTIPLE DRUG
SOURCE (EFF 9/93)

0633 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-RESTRICTIVE
PRESCRIPTION (EFF 9/93)

0634 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-EPO UNDER
10,000 UNITS

0635 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-EPO 10,000
UNITS OR MORE

0636 = DRUGS REQUIRING SPECIFIC IDENTIFICATION-DETAILED
CODING (EFF 3/92)

0637 = SELF-ADMINISTERED DRUGS ADMINISTERED IN AN
EMERGENCY SITUATION - NOT REQUIRING DETAILED
CODING

0640 = HOME IV THERAPY-GENERAL CLASSIFICATION
(EFF 10/94)

0641 = HOME IV THERAPY-NONROUTINE NURSING
(EFF 10/94)

0642 = HOME IV THERAPY-IV SITE CARE, CENTRAL LINE
(EFF 10/94)

0643 = HOME IV THERAPY-IV START/CHANGE PERIPHERAL LINE
(EFF 10/94)

0644 = HOME IV THERAPY-NONROUTINE NURSING, PERIPHERAL LINE

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(EFF 10/94)
0645 = HOME IV THERAPY-TRAIN PATIENT/CAREGIVER, CENTRAL
LINE (EFF 10/94)
0646 = HOME IV THERAPY-TRAIN DISABLED PATIENT, CENTRAL
LINE (EFF 10/94)
0647 = HOME IV THERAPY-TRAIN PATIENT/CAREGIVER, PERIPHERAL
LINE (EFF 10/94)

REVENUE CENTER TABLE

0648 = HOME IV THERAPY-TRAIN DISABLED PATIENT, PERIPHERAL
LINE (EFF 10/94)
0649 = HOME IV THERAPY-OTHER IV THERAPY SERVICES
(EFF 10/94)
0650 = HOSPICE SERVICES-GENERAL CLASSIFICATION
0651 = HOSPICE SERVICES-ROUTINE HOME CARE
0652 = HOSPICE SERVICES-CONTINUOUS HOME CARE-1/2
0655 = HOSPICE SERVICES-INPATIENT CARE
0656 = HOSPICE SERVICES-GENERAL INPATIENT CARE
(NON-RESPITE)
0657 = HOSPICE SERVICES-PHYSICIAN SERVICES
0659 = HOSPICE SERVICES-OTHER
0660 = RESPITE CARE (HHA)-GENERAL CLASSIFICATION
(EFF 9/93)
0661 = RESPITE CARE (HHA)-HOURLY CHARGE/SKILLED NURSING
(EFF 9/93)
0662 = RESPITE CARE (HHA)-HOURLY CHARGE/HOME HEALTH AIDE/
HOMEMAKER (EFF 9/93)
0670 = OP SPECIAL RESIDENCE CHARGES - GENERAL
CLASSIFICATION
0671 = OP SPECIAL RESIDENCE CHARGES - HOSPITAL BASED
0672 = OP SPECIAL RESIDENCE CHARGES - CONTRACTED
0679 = OP SPECIAL RESIDENCE CHARGES - OTHER SPECIAL
RESIDENCE CHARGES
0700 = CAST ROOM-GENERAL CLASSIFICATION
0709 = CAST ROOM-OTHER
0710 = RECOVERY ROOM-GENERAL CLASSIFICATION
0719 = RECOVERY ROOM-OTHER
0720 = LABOR ROOM/DELIVERY-GENERAL CLASSIFICATION
0721 = LABOR ROOM/DELIVERY-LABOR
0722 = LABOR ROOM/DELIVERY-DELIVERY
0723 = LABOR ROOM/DELIVERY-CIRCUMCISION
0724 = LABOR ROOM/DELIVERY-BIRTHING CENTER
0729 = LABOR ROOM/DELIVERY-OTHER

0730 = EKG/ECG-GENERAL CLASSIFICATION
0731 = EKG/ECG-HOLTER MONITER
0732 = EKG/ECG-TELEMETRY (INCLUDE FETAL MONITERING UNTIL
9/93)
0739 = EKG/ECG-OTHER
0740 = EEG-GENERAL CLASSIFICATION
0749 = EEG (ELECTROENCEPHALOGRAM)-OTHER
0750 = GASTRO-INTESTINAL SERVICES-GENERAL CLASSIFICATION
0759 = GASTRO-INTESTINAL SERVICES-OTHER
0760 = TREATMENT OR OBSERVATION ROOM-GENERAL
CLASSIFICATION
0761 = TREATMENT OR OBSERVATION ROOM-TREATMENT ROOM
(EFF 9/93)
0762 = TREATMENT OR OBSERVATION ROOM-OBSERVATION ROOM
(EFF 9/93)
0769 = TREATMENT OR OBSERVATION ROOM-OTHER
0770 = PREVENTATIVE CARE SERVICES-GENERAL CLASSIFICATION
(EFF 10/94)
0771 = PREVENTATIVE CARE SERVICES-VACCINE ADMINISTRATION
(EFF 10/94)
0779 = PREVENTATIVE CARE SERVICES-OTHER (EFF 10/94)
0780 = TELEMEDICINE - GENERAL CLASSIFICATION
(EFF 10/97)
0789 = TELEMEDICINE - TELEMEDICINE (EFF 10/97)
REVENUE CENTER TABLE

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0790 = LITHOTRIPSY-GENERAL CLASSIFICATION
0799 = LITHOTRIPSY-OTHER
0800 = INPATIENT RENAL DIALYSIS-GENERAL CLASSIFICATION
0801 = INPATIENT RENAL DIALYSIS-INPATIENT HEMODIALYSIS
0802 = INPATIENT RENAL DIALYSIS-INPATIENT PERITONEAL
(NON-CAPD)
0803 = INPATIENT RENAL DIALYSIS-INPATIENT CAPD
0804 = INPATIENT RENAL DIALYSIS-INPATIENT CCPD
0809 = INPATIENT RENAL DIALYSIS-OTHER INPATIENT DIALYSIS
0810 = ORGAN ACQUISITION-GENERAL CLASSIFICATION
0811 = ORGAN ACQUISITION-LIVING DONOR (EFF 10/94);
PRIOR TO 10/94, DEFINED AS LIVING DONOR KIDNEY
0812 = ORGAN ACQUISITION-CADAVER DONOR (EFF 10/94);
PRIOR TO 10/94, DEFINED AS CADAVER DONOR KIDNEY
0813 = ORGAN ACQUISITION-UNKNOWN DONOR (EFF 10/94)
PRIOR TO 10/94, DEFINED AS UNKNOWN DONOR KIDNEY
0814 = ORGAN ACQUISITION - UNSUCCESSFUL ORGAN SEARCH-

DONOR BANK CHARGES (EFF 10/94); PRIOR TO 10/94,
DEFINED AS OTHER KIDNEY ACQUISITION
0815 = ORGAN ACQUISITION-CADAVER DONOR-HEART
(OBSOLETE, EFF 10/94)
0816 = ORGAN ACQUISITION-OTHER HEART ACQUISITION
(OBSOLETE, EFF 10/94)
0817 = ORGAN ACQUISITION-DONOR-LIVER
(OBSOLETE, EFF 10/94)
0819 = ORGAN ACQUISITION-OTHER DONOR (EFF 10/94);
PRIOR TO 10/94, DEFINED AS OTHER
0820 = HEMODIALYSIS OP OR HOME DIALYSIS-GENERAL
CLASSIFICATION
0821 = HEMODIALYSIS OP OR HOME DIALYSIS-HEMODIALYSIS-
COMPOSITE OR OTHER RATE
0822 = HEMODIALYSIS OP OR HOME DIALYSIS-HOME SUPPLIES
0823 = HEMODIALYSIS OP OR HOME DIALYSIS-HOME EQUIPMENT
0824 = HEMODIALYSIS OP OR HOME DIALYSIS-MAINTENANCE/100%
0825 = HEMODIALYSIS OP OR HOME DIALYSIS-SUPPORT SERVICES
0829 = HEMODIALYSIS OP OR HOME DIALYSIS-OTHER
0830 = PERITONEAL DIALYSIS OP OR HOME-GENERAL
CLASSIFICATION
0831 = PERITONEAL DIALYSIS OP OR HOME-PERITONEAL-
COMPOSITE OR OTHER RATE
0832 = PERITONEAL DIALYSIS OP OR HOME-HOME SUPPLIES
0833 = PERITONEAL DIALYSIS OP OR HOME-HOME EQUIPMENT
0834 = PERITONEAL DIALYSIS OP OR HOME-MAINTENANCE/100%
0835 = PERITONEAL DIALYSIS OP OR HOME-SUPPORT SERVICES
0839 = PERITONEAL DIALYSIS OP OR HOME-OTHER
0840 = CAPD OUTPATIENT-GENERAL CLASSIFICATION
0841 = CAPD OUTPATIENT-CAPD/COMPOSITE OR OTHER RATE
0842 = CAPD OUTPATIENT-HOME SUPPLIES
0843 = CAPD OUTPATIENT-HOME EQUIPMENT
0844 = CAPD OUTPATIENT-MAINTENANCE/100%
0845 = CAPD OUTPATIENT-SUPPORT SERVICES
0849 = CAPD OUTPATIENT-OTHER
0850 = CCPD OUTPATIENT-GENERAL CLASSIFICATION
0851 = CCPD OUTPATIENT-CCPD/COMPOSITE OR OTHER RATE
0852 = CCPD OUTPATIENT-HOME SUPPLIES
0853 = CCPD OUTPATIENT-HOME EQUIPMENT
0854 = CCPD OUTPATIENT-MAINTENANCE/100%
0855 = CCPD OUTPATIENT-SUPPORT SERVICES

REVENUE CENTER TABLE

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0859 = CCPD OUTPATIENT-OTHER
0880 = MISCELLANEOUS DIALYSIS-GENERAL CLASSIFICATION
0881 = MISCELLANEOUS DIALYSIS-ULTRAFILTRATION
0882 = MISCELLANEOUS DIALYSIS-HOME DIALYSIS AIDE VISIT
(EFF 9/93)
0889 = MISCELLANEOUS DIALYSIS-OTHER
0890 = OTHER DONOR BANK-GENERAL CLASSIFICATION; CHANGED TO
RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
0891 = OTHER DONOR BANK-BONE; CHANGED TO
RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
0892 = OTHER DONOR BANK-ORGAN (OTHER THAN KIDNEY); CHANGED
TO RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
0893 = OTHER DONOR BANK-SKIN; CHANGED TO
RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
0899 = OTHER DONOR BANK-OTHER; CHANGED TO
RESERVED FOR NATIONAL ASSIGNMENT (EFF 4/94)
0900 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-GENERAL
CLASSIFICATION
0901 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-ELECTROSHOCK
TREATMENT
0902 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-MILIEU
THERAPY
0903 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-PLAY
THERAPY
0904 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-ACTIVITY
THERAPY (EFF 4/94)
0909 = PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-OTHER
0910 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GENERAL
CLASSIFICATION
0911 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-REHABILITATION
0912 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-DAY CARE-
REDEFINED 10/97 TO LESS INTENSIVE
0913 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-NIGHT CARE
REDEFINED 10/97 TO INTENSIVE
0914 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-INDIVIDUAL
THERAPY
0915 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GROUP THERAPY
0916 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-FAMILY THERAPY
0917 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-BIOFEEDBACK
0918 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-TESTING
0919 = PSYCHIATRIC/PSYCHOLOGICAL SERVICES-OTHER
0920 = OTHER DIAGNOSTIC SERVICES-GENERAL CLASSIFICATION
0921 = OTHER DIAGNOSTIC SERVICES-PERIPHERAL VASCULAR LAB
0922 = OTHER DIAGNOSTIC SERVICES-ELECTROMYEOGRAM

0923 = OTHER DIAGNOSTIC SERVICES-PAP SMEAR
0924 = OTHER DIAGNOSTIC SERVICES-ALLERGY TEST
0925 = OTHER DIAGNOSTIC SERVICES-PREGNANCY TEST
0929 = OTHER DIAGNOSTIC SERVICES-OTHER
0940 = OTHER THERAPEUTIC SERVICES-GENERAL CLASSIFICATION
0941 = OTHER THERAPEUTIC SERVICES-RECREATIONAL THERAPY
0942 = OTHER THERAPEUTIC SERVICES-EDUCATION/TRAINING
(INCLUDE DIABETES DIET TRAINING)
0943 = OTHER THERAPEUTIC SERVICES-CARDIAC REHABILITATION
0944 = OTHER THERAPEUTIC SERVICES-DRUG REHABILITATION
0945 = OTHER THERAPEUTIC SERVICES-ALCOHOL
REHABILITATION
0946 = OTHER THERAPEUTIC SERVICES-ROUTINE COMPLEX
MEDICAL EQUIPMENT

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REVENUE CENTER TABLE

0947 = OTHER THERAPEUTIC SERVICES-ANCILLARY COMPLEX
MEDICAL EQUIPMENT (EFF 3/92)
0949 = OTHER THERAPEUTIC SERVICES-OTHER
0951 = PROFESSIONAL FEES-ATHLETIC TRAINING
0952 = PROFESSIONAL FEES-KINESIOTHERAPY
0960 = PROFESSIONAL FEES-GENERAL CLASSIFICATION
0961 = PROFESSIONAL FEES-PSYCHIATRIC
0962 = PROFESSIONAL FEES-OPHTHALMOLOGY
0963 = PROFESSIONAL FEES-ANESTHESIOLOGIST (MD)
0964 = PROFESSIONAL FEES-ANESTHETIST (CRNA)
0969 = PROFESSIONAL FEES-OTHER
0971 = PROFESSIONAL FEES-LABORATORY
0972 = PROFESSIONAL FEES-RADIOLOGY DIAGNOSTIC
0973 = PROFESSIONAL FEES-RADIOLOGY THERAPEUTIC
0974 = PROFESSIONAL FEES-NUCLEAR MEDICINE
0975 = PROFESSIONAL FEES-OPERATING ROOM
0976 = PROFESSIONAL FEES-RESPIRATORY THERAPY
0977 = PROFESSIONAL FEES-PHYSICAL THERAPY
0978 = PROFESSIONAL FEES-OCCUPATIONAL THERAPY
0979 = PROFESSIONAL FEES-SPEECH PATHOLOGY
0981 = PROFESSIONAL FEES-EMERGENCY ROOM
0982 = PROFESSIONAL FEES-OUTPATIENT SERVICES
0983 = PROFESSIONAL FEES-CLINIC
0984 = PROFESSIONAL FEES-MEDICAL SOCIAL SERVICES
0985 = PROFESSIONAL FEES-EKG
0986 = PROFESSIONAL FEES-EEG
0987 = PROFESSIONAL FEES-HOSPITAL VISIT

0988 = PROFESSIONAL FEES-CONSULTATION
0989 = PROFESSIONAL FEES-PRIVATE DUTY NURSE
0990 = PATIENT CONVENIENCE ITEMS-GENERAL CLASSIFICATION
0991 = PATIENT CONVENIENCE ITEMS-CAFETERIA/GUEST TRAY
0992 = PATIENT CONVENIENCE ITEMS-PRIVATE LINEN SERVICE
0993 = PATIENT CONVENIENCE ITEMS-TELEPHONE/TELEGRAPH
0994 = PATIENT CONVENIENCE ITEMS-TV/RADIO
0995 = PATIENT CONVENIENCE ITEMS-NONPATIENT ROOM RENTALS
0996 = PATIENT CONVENIENCE ITEMS-LATE DISCHARGE CHARGE
0997 = PATIENT CONVENIENCE ITEMS-ADMISSION KITS
0998 = PATIENT CONVENIENCE ITEMS-BEAUTY SHOP/BARBER
0999 = PATIENT CONVENIENCE ITEMS-OTHER

NOTE: FOLLOWING REVENUE CODES REPORTED
FOR NHCMQ (RUGS) DEMO CLAIMS EFFECTIVE
2/96.

9000 = RUGS-NO MDS ASSESSMENT AVAILABLE
9001 = REDUCED PHYSICAL FUNCTIONS-
RUGS PA1/ADL INDEX OF 4-5
9002 = REDUCED PHYSICAL FUNCTIONS-
RUGS PA2/ADL INDEX OF 4-5
9003 = REDUCED PHYSICAL FUNCTIONS-
RUGS PB1/ADL INDEX OF 6-8
9004 = REDUCED PHYSICAL FUNCTIONS-
RUGS PB2/ADL INDEX OF 6-8
9005 = REDUCED PHYSICAL FUNCTIONS-
RUGS PC1/ADL INDEX OF 9-10
9006 = REDUCED PHYSICAL FUNCTIONS-
RUGS PC2/ADL INDEX OF 9-10
9007 = REDUCED PHYSICAL FUNCTIONS-

REVENUE CENTER TABLE

RUGS PD1/ADL INDEX OF 11-15
9008 = REDUCED PHYSICAL FUNCTIONS-
RUGS PD2/ADL INDEX OF 11-15
9009 = REDUCED PHYSICAL FUNCTIONS-
RUGS PE1/ADL INDEX OF 16-18
9010 = REDUCED PHYSICAL FUNCTIONS-
RUGS PE2/ADL INDEX OF 16-18
9011 = BEHAVIOR ONLY PROBLEMS-
RUGS BA1/ADL INDEX OF 4-5
9012 = BEHAVIOR ONLY PROBLEMS-

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RUGS BA2/ADL INDEX OF 4-5
9013 = BEHAVIOR ONLY PROBLEMS-
RUGS BB1/ADL INDEX OF 6-10
9014 = BEHAVIOR ONLY PROBLEMS-
RUGS BB2/ADL INDEX OF 6-10
9015 = IMPAIRED COGNITION-
RUGS IA1/ADL INDEX OF 4-5
9016 = IMPAIRED COGNITION-
RUGS IA2/ADL INDEX OF 4-5
9017 = IMPAIRED COGNITION-
RUGS IB1/ADL INDEX OF 6-10
9018 = IMPAIRED COGNITION-
RUGS IB2/ADL INDEX OF 6-10
9019 = CLINICALLY COMPLEX-
RUGS CA1/ADL INDEX OF 4-5
9020 = CLINICALLY COMPLEX-
RUGS CA2/ADL INDEX OF 4-5D
9021 = CLINICALLY COMPLEX-
RUGS CB1/ADL INDEX OF 6-10
9022 = CLINICALLY COMPLEX-
RUGS CB2/ADL INDEX OF 6-10D
9023 = CLINICALLY COMPLEX-
RUGS CC1/ADL INDEX OF 11-16
9024 = CLINICALLY COMPLEX-
RUGS CC2/ADL INDEX OF 11-16D
9025 = CLINICALLY COMPLEX-
RUGS CD1/ADL INDEX OF 17-18
9026 = CLINICALLY COMPLEX-
RUGS CD2/ADL INDEX OF 17-18D
9027 = SPECIAL CARE-
RUGS SSA/ADL INDEX OF 7-13
9028 = SPECIAL CARE-
RUGS SSB/ADL INDEX OF 14-16
9029 = SPECIAL CARE-
RUGS SSC/ADL INDEX OF 17-18
9030 = EXTENSIVE SERVICES-
RUGS SE1/1 PROCEDURE
9031 = EXTENSIVE SERVICES-
RUGS SE2/2 PROCEDURES
9032 = EXTENSIVE SERVICES-
RUGS SE3/3 PROCEDURES
9033 = LOW REHABILITATION-
RUGS RLA/ADL INDEX OF 4-11
9034 = LOW REHABILITATION-

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RUGS RLB/ADL INDEX OF 12-18
9035 = MEDIUM REHABILITATION-
RUGS RMA/ADL INDEX OF 4-7
9036 = MEDIUM REHABILITATION-
REVENUE CENTER TABLE

RUGS RMB/ADL INDEX OF 8-15
9037 = MEDIUM REHABILITATION-
RUGS RMC/ADL INDEX OF 16-18
9038 = HIGH REHABILITATION-
RUGS RHA/ADL INDEX OF 4-7
9039 = HIGH REHABILITATION-
RUGS RHB/ADL INDEX OF 8-11
9040 = HIGH REHABILITATION-
RUGS RHC/ADL INDEX OF 12-14
9041 = HIGH REHABILITATION-
RUGS RHD/ADL INDEX OF 15-18
9042 = VERY HIGH REHABILITATION-
RUGS RVA/ADL INDEX OF 4-7
9043 = VERY HIGH REHABILITATION-
RUGS RVB/ADL INDEX OF 8-13
9044 = VERY HIGH REHABILITATION-
RUGS RVC/ADL INDEX OF 14-18

CHANGES EFFECTIVE FOR PROVIDERS ENTERING
RUGS DEMO PHASE III AS OF 1/1/97 OR LATER

9019 = CLINICALLY COMPLEX-
RUGS CA1/ADL INDEX OF 11
9020 = CLINICALLY COMPLEX-
RUGS CA2/ADL INDEX OF 11D
9021 = CLINICALLY COMPLEX-
RUGS CB1/ADL INDEX OF 12-16
9022 = CLINICALLY COMPLEX-
RUGS CB2/ADL INDEX OF 12-16D
9023 = CLINICALLY COMPLEX-
RUGS CC1/ADL INDEX OF 17-18
9024 = CLINICALLY COMPLEX-
RUGS CC2/ADL INDEX OF 17-18D
9025 = SPECIAL CARE-
RUGS SSA/ADL INDEX OF 14
9026 = SPECIAL CARE-
RUGS SSB/ADL INDEX OF 15-16

9027 = SPECIAL CARE-
RUGS SSC/ADL INDEX OF 17-18
9028 = EXTENSIVE SERVICES-
RUGS SE1/ADL INDEX 7-18/1 PROCEDURE
9029 = EXTENSIVE SERVICES-
RUGS SE2/ADL INDEX 7-18/2 PROCEDURES
9030 = EXTENSIVE SERVICES-
RUGS SE3/ADL INDEX 7-18/3 PROCEDURES
9031 = LOW REHABILITATION-
RUGS RLA/ADL INDEX OF 4-13
9032 = LOW REHABILITATION-
RUGS RLB/ADL INDEX OF 14-18
9033 = MEDIUM REHABILITATION-
RUGS RMA/ADL INDEX OF 4-7
9034 = MEDIUM REHABILITATION-
RUGS RMB/ADL INDEX OF 8-14
9035 = MEDIUM REHABILITATION-
RUGS RMC/ADL INDEX OF 15-18
9036 = HIGH REHABILITATION-
RUGS RHA/ADL INDEX OF 4-7
9037 = HIGH REHABILITATION-

REVENUE CENTER TABLE

RUGS RHB/ADL INDEX OF 8-12
9038 = HIGH REHABILITATION-
RUGS RHC/ADL INDEX OF 13-18
9039 = VERY HIGH REHABILITATION-
RUGS RVA/ADL INDEX OF 4-8
9040 = VERY HIGH REHABILITATION-
RUGS RVB/ADL INDEX OF 9-15
9041 = VERY HIGH REHABILITATION-
RUGS RVC/ADL INDEX OF 16
9042 = VERY HIGH REHABILITATION-
RUGS RUA/ADL INDEX OF 4-8
9043 = VERY HIGH REHABILITATION-
RUGS RUB/ADL INDEX OF 9-15
9044 = ULTRA HIGH REHABILITATION-
RUGS RUC/ADL INDEX OF 16-18

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